regulations concerning physician direction of concurrent anesthesia procedures while a physician is checking and discharging patients in the recovery room. We included the effect of these regulations in our analysis published in the March 1983 rule (48 FR 8943).

C. Information Collection Requirements

This final rule does not contain information collection requirements that are subject to Executive Office of Management and Budget review under the Paperwork Reduction Act of 1980, Pub. L. 96–511.

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (agreements), End-stage renal disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

(Secs. 1102, 1814(b), 1815, 1832, 1833(a), 1842(b), 1861(b), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act, as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395k, 1395l(a), 1395u(b), 1395x(b), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx))

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program, No. 13.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 17, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 25, 1983.

Margaret M. Heckler,

Secretary.

[FR Doc. 83-23802 Filed 8-31-83; 8:45 am]

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federal register

Thursday
September 1, 1983

Part III

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Schedule of Target Rate Percentages for Limits on the Rate of Hospital Cost Increases and Updating Factors for Transition Prospective Payment Rates; Interim Final Notice With Comment Period.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Medicare Program; Schedule of Target Rate Percentages for Limits on the Rate of Hospital Cost Increases and Updating Factors for Transition Prospective Payment Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final notice with comment period.

SUMMARY: This interim notice sets forth target rate percentages needed to limit the rate of increase of hospital inpatient operating costs and related updating factors for use in computing the hospital-specific portions of transition payment rates under the prospective payment system. The notice also explains which hospitals are subject to the ceiling on the rate of hospital cost increases (as established by the Tax Equity and Fiscal Responsibility Act of 1982, and amended by the Social Security Amendments of 1983), and describes how the calendar year target rate percentages are applied to cost reporting periods that span two calendar years.

EFFECTIVE DATE: See the text of this notice for an explanation of the application of these target rate percentages to particular cost reporting periods.

COMMENT DATE: To assure consideration, comments should be received by October 16, 1983.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-264-FNC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to BERC-264-FNC.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication, in Room 309-G of the Department's offices at 200 Independence Ave., S.W., Washington, D.C. 20201, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (200-245-7890).

FOR FURTHER INFORMATION CONTACT: Terence Skelly, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

Section 101(a)(1) of the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA (Pub. L. 97-248, enacted September 3, 1982), added two new sections 1886(a) and 1886(b) to the Social Security Act (the Act), supplementing section 1861(v) of the Act by providing for a limit on the amount of inpatient operating cost per discharge and a new three-year control on the rate of increase of operating costs of inpatient hospital services. (This rate of increase limit is separate and different from the type of limit established under section 1861(v) (as amended by section 223 of Pub. L. 92-603) and section 1886(a), which were applied to the level of costs, rather than to their rate of increase.) This new provision requires that we establish a ceiling on the rate of increase of operating costs per case for inpatient hospital services and provides for both incentive payments for hospitals that keep their cost below the target, and a reduction in the amount of reimbursement for hospitals that incur costs greater than the target.

On September 30, 1982, we published interim final regulations (47 FR 43282) implementing section 1886(b) of the Act for hospital cost reporting periods beginning on or after October 1, 1982 (42 CFR 405.463). The interim rules had a 60-day comment period, ending November 29, 1982, during which we received approximately 100 comments on the regulations.

As a result of review of comments on and further analysis of the interim regulations, we published final regulations making certain amendments to the interim rules and establishing them as permanent program regulations (FR Doc. 83-23800, Part V of the issue of August 30, 1983). In those final rules, we amended the interim rate of increase regulations (42 CFR 405.463) in two ways. First, we excluded certain kidney acquisition costs from those inpatient operating costs subject to the rate of increase ceiling. Second, we decided to revise the method of updating and providing notice of target rate percentages included in the interim regulations. Instead of requiring intermediaries to use the most recent percentage published in the annual cost limits notice, we decided to publish appropriate percentages quarterly. Those amendments provided that intermediaries use the most recent percentage available as of the close of the hospital's cost reporting period, and that HCFA publish revised market basket percentages each quarter in the Provider Reimbursement Manual (HCFA Pub. 15-1), and also publish the updated percentages in an appropriated **Federal Register** notice.

However, amendments to section 1886(b) made by Title VI of Pub. L. 98-21, enacted April 20, 1983, which also established the prospective payment system, require us to further amend the regulation on the rate of increase ceiling.

We are implementing the amendments made to section 1886(b) by section 601 of Pub. L. 98-21 by amending our regulations at 42 CFR 405.463 as part of the conforming changes made in the interim rules implementing the prospective payment system, published elsewhere in this issue of the **Federal Register**. The changes are as follows:

- We are deleting all references to the inapplicability of the rate of increase limits to cost reporting periods beginning on or after October 1, 1985. Section 405.463 will now apply indefinitely (section 1886(b)(2) of the Act, as repealed by section 601(b)(4)).
- We are clarifying the costs subject to the ceiling, specifying that for cost reporting periods beginning on or after October 1, 1983, capital-related costs (including the return on equity which is treated like a capital-related cost), and the direct costs of approved medical education programs will be excluded from the ceiling (sections 1886(a)(4) and (b)(4)(A) of the Act, as amended by sections 601(a)(2) and 601(b)).
- Hospitals must treat such costs consistently with treatment in their base period.
- We are providing for adjustment of base period costs to account for FICA taxes incurred by a non-profit hospital that had not incurred such taxes for all its employees in its base period (section 1886(b)(6) of the Act, as amended by section 601(b)(9)).
- Hospitals engaged in kidney transplantation encounter a unique set of circumstances with respect to their cost experience because of special provisions of the law applicable to end stage renal disease (ESRD). Kidney acquisition costs are reimbursed pursuant to section 1981 of the Act, under which the Secretary reimburses: (1) the hospital for obtaining kidneys from Organ Procurement Agencies (OPA) in amounts not to exceed the costs incurred by OPAs and histocompatability laboratories; and (2) the reasonable expenses incurred by an individual donor. In view of the unique characteristics of organ procurement activities and the desirability of maintaining an adequate supply of kidneys, certain kidney acquisition costs will not be subject to the rate of increase control.

• We are providing that the target rate percentages by which target amounts will be determined will be established prospectively and published in a quarterly **Federal Register** notice. Target rate percentages will still be prorated for cost reporting periods that span portions of two calendar years. Further, we have made it explicit in the regulations that we will apply the appropriate target rate percentage prospectively, and will not retroactively adjust the prospectively set target rate percentages if the actual increase in the market basket differs from the prospective estimate.

II. How the Rate of Increase Ceiling Works

The regulations, as amended, establish a target rate percentage system to be applied to control the rates of increase of total hospital inpatient operating costs per case effective for 12-month cost reporting periods beginning on or after October 1, 1982 (see our regulations at 42 CFR 405.463(b)). The target rate percentage equals the market basket index plus one percentage point. In the first year, this target rate percentage will be applied to each hospital's allowable inpatient operating cost per discharge for its immediately preceding cost reporting period (§ 405.463(c)). In the case of a hospital whose first reporting period subject to the rate-of-increase control begins October 1, 1982, the target rate percentage would be applied to the allowable inpatient operating cost per discharge for the period beginning October 1, 1981. The resulting amount will be that hospital's target amount for inpatient operating cost per discharge in the first cost reporting period subject to this provision (§ 405.463(b)). The rules provide that in each subsequent cost reporting period, the target amount will be computed by applying the applicable target rate percentage to the previous period's target amount (§ 405.463(c)(4)(ii)).

If a hospital's costs in a subject cost reporting period are below its target amount, we will pay the hospital its actual costs per case plus the lower of 50 percent of the difference between the hospital's cost per case and the target amount, or 5 percent of the target amount. If a hospital's cost in a subject period is higher than its target amount, we will pay, in the first two years, the target amount plus 25 percent of the excess costs, and, in the third year, the target amount (§ 405.463(d)). For periods beginning on or after October 1, 1982 and before October 1, 1983, the maximum payment is limited by the TEFRA limits on total inpatient operating cost established under section 1886(a).

New hospitals, risk-basis health maintenance organizations, and hospitals paid under the prospective payment system are exempt from the rate of increase ceiling (§ 405.463(f)). A hospital subject to the ceiling may request an exception to it on the basis of a change in case mix or extraordinary circumstances that are beyond the hospital's control and which have substantial cost effects (§ 403.463(g)). The ceiling will not apply to a cost reporting period of less than 12 months that occurs along with a change in operations of the facility as a result of changes in ownership, merger or consolidation (§ 405.463(b)(3)). In addition, HCFA may adjust a hospital's cost per case to take into account factors, such as a decrease in the inpatient hospital services, that would otherwise distort the comparison of costs between reporting periods (§ 405.463(h)).

III. Hospitals Subject to the Rate of Increase Ceiling

Under the rules implementing TEFRA, only new hospitals and risk-basis health maintenance organizations (HMOs) were exempt from the rate of increase ceiling. All other hospitals participating in Medicare were subject to this new limit on inpatient operating costs for cost reporting periods beginning on or after October 1, 1982.

Under Pub. L. 98–21, most participating short-term acute care hospitals will be paid under the prospective payment system and will not be subject to the rate of increase ceiling for cost reporting periods beginning on or after October 1, 1983. Rather, this ceiling will apply to hospitals and hospital units (that is, distinct part psychiatric and rehabilitation units) that are excluded from the prospective payment system and paid on a reasonable cost basis under our regulations at 42 CFR Part 405, Subpart D. The criteria for identifying these hospitals and units are set forth in the interim regulations published elsewhere in this issue, at § 405.471(c).

In summary, the following classes of hospitals will be subject to the rate of increase ceiling for cost reporting periods beginning on or after October 1, 1983:

- Psychiatric hospitals;
- Rehabilitation hospitals;
- Psychiatric and rehabilitation distinct part units;
- Children's hospitals;
- Long-term hospitals; and
- Hospitals outside the 50 States and the District of Columbia (for example, Puerto Rico).

IV. Inpatient Operating Costs Subject to the Rate of Increase Ceiling

The rate of increase ceiling applies to operating costs incurred by a hospital in furnishing inpatient hospital services. These operating costs *include* the operating costs related to routine services, such as nursing services and room and board, ancillary services, and special care units.

For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, inpatient operating costs *exclude* capital-related costs, the direct costs of medical education, malpractice insurance costs, and certain costs of kidney acquisition. However, section 601(a)(2) of Pub. L. 98–21 amended section 1886(a)(4) of the Act, which defines inpatient operating costs, effective for cost reporting periods beginning on or after October 1, 1983. For those cost reporting periods, costs *excluded* from operating costs are capital-related costs, direct medical education costs, and certain kidney acquisition costs. A new regulation section describing capital-related costs is included in the interim rules implementing the prospective payment system, at § 405.414. Those interim rules also amend the regulations describing direct medical education costs, at § 405.421, as explained in the preamble to the interim rules.

V. Application of Target Rate Percentages

As mentioned above, we are, beginning with this notice, publishing quarterly notices of target rate percentages. Each of these notices will include tables (see below) of target rate percentagers set at the market basket index plus one percentage point, in accordance with section 1886(b)(3)(B) of the Act. The market basket index is an estimate of the annual rate of increase in the costs of certain goods and services used by hospitals in the production of inpatient care. The items and services used in the market basket index have been selected and weighted to reflect the effect that general price changes have on hospital inpatient operating costs.

The calculation of the market basket index is explained in the interim rules on prospective payment. We have revised the market basket index to take into account the inclusion of malpractice insurance among inpatient operating costs. For administrative simplicity, and because the minimal increase in the

market basket estimates resulting from this change will not disadvantage any hospitals, we have decided to use the same market basket index for all cost reporting periods subject to this notice.

When a hospital's cost reporting period spans two calendar years (i.e., begins in one calendar year and ends in another), the hospital's target rate percentage will be determined by prorating the applicable percentages for the calendar years the period spans.

For 12-month cost reporting periods beginning on or after October 1, 1982, and before October 1, 1983, the applicable target rate precentages will be taken from the notice published for the quarter in which the hospital's cost reporting period ends. Thus, the percentages published in this notice will be used to determine the rate of increase ceilings for hospital cost reporting periods *ending* on or after September 30, 1983 and *before* January 1, 1984. These percentages will not be adjusted later if the actual rates of increase differ from the market basket estimates.

Cost reporting periods of other than 12 months that *do not* occur along with a change in operations of the facility as a result of changes in ownership, merger, or consolidation, are subject to the rate of increase limit. In such cases, the applicable target rate percentage must be obtained from HCFA. We will adjust the target percentage rate to reflect fewer months in the case of a short reporting period, using a monthly factor corresponding to the annual percentage rate and apply the ceiling. (We will also use such a monthly factor to make adjustments for cost reporting periods longer than 12 months.)

As noted above, Pub. L. 98–21 specified that, effective for cost reporting periods beginning on or after October 1, 1983, the target rate percentages must be established prospectively. Therefore, the target rate percentages published in this notice will also be applied to 12-month cost reporting periods *beginning* on or after October 1, 1983 and before January 1, 1984. Again, these percentage rates will not be revised later based on actual market basket experience.

A hospital's intermediary will prorate the appropriate calendar year percentages from Table A to determine the target rate percentage for a hospital with a cost reporting period that spans two calendar years. The intermediary will compute a prorated target rate percentage as follows:

1. The intermediary will determine the number of months in each calendar year covered by the hospital's cost reporting period.

2. The number of months for each calendar year will be divided by twelve and multiplied by the applicable target rate percentage for that year.

3. The two resulting percentages are added, yielding the hospital's target rate percentage for that cost reporting period.

Example A: Hospital A has a cost reporting period beginning October 1, 1982 and ending September 30, 1983. Therefore, there are 3 months of the period in 1982 and 9 months of the period in 1983.

The applicable calendar year target rate percentages are:

1982.....10.3 (0.103)
1983.....7.2 (0.072)

Hospital A's rate percentage is calculated as follows:

$$\frac{(3\times 0.103)}{12} + \frac{(9\times 0.072)}{12} = 8.0\%$$

Example B:

Hospital B has a cost reporting period beginning November 1, 1983 and ending October 31, 1984. Therefore, there are 2 months of the period in 1983 and 10 in 1984.

The applicable calendar year target rate percentages are:

1983.....7.2 (0.072)
1984.....6.8 (0.068)

Hospital B's target rate percentage is calculated as follows:

$$\frac{(2\times 0.072)}{12} + \frac{(10\times 0.068)}{12} = 6.9\%$$

Note that in Example A, in which the cost reporting period begins *before* October 1, 1983, the resulting percentage will be applied retrospectively. In Example B, the resulting percentage will be applied prospectively, since the cost reporting period begins *after* October 1, 1983.

VI. Updating Factors for Determining Transition Payment Rates Under the Prospective Payment System

The preamble to the interim final rules implementing the prospective payment system established by Title VI of Pub. L. 98–21 and amending the regulations governing the rate of increase ceiling, which are published elsewhere in this issue of the **Federal Register**, explains how prospective payment rates during the initial three-year transition period will be determined using a blend of Federal prospective payment rates (based on standardized payment amounts) and rates based on each hospital's cost experience. The hospital-specific portion of the transition payment rates will be based on per case target amounts computed generally in the same way as are amounts for hospitals subject to the rate of increase ceiling. This computation is described in the interim regulations published elsewhere in this issue at 42 CFR 405.474. The differences will be that, for hospitals paid under the prospective payment system:

- The target amounts will be standardized to take a hospital's historical case mix into account;
- The case-mix adjusted base year costs will be reduced to take into account outlier payments; and
- The applicable updating factors will be based on the rate of increase target rate percentage as adjusted for budget neutrality, in accordance with section 1886(e)(1)(A) of the Social Security Act.

Therefore, for cost reporting periods beginning on or after October 1, 1983, we are publishing in Table B, below, updating factors for computing the hospital-specific portion of transition period prospective payment rates. The updating factors are computed by adjusting the calendar year target rate percentages by an actuarily estimated factor. This adjustment is necessary to implement the budget neutrality provisions of the statute. The factor is computed to ensure that the estimated amount of aggregate Medicare payments made based on the hospital-specific portion of the transition payment rates for Federal fiscal year 1984 is neither greater nor less than 75 percent of the payment amounts that would have been payable for the inpatient operating costs incurred by those same hospitals for fiscal year 1984 under the Social Security Act as it was in effect on April 19, 1983.

VII. Tables of Target Rate Percentages and Hospital-Specific Portion Updating Factors

TABLE A.—TARGET RATE PERCENTAGES

[Applicable to hospitals subject to the rate of increase ceiling]

Calendar year	Estimated market basket index (percent) [1]	Target rate percentage
1982	9.3	10.3
1983	6.2	7.2
1984	5.8	6.8
1985	6.2	7.2

[1] This market basket index includes malpractice insurance costs.

TABLE B.—UPDATING FACTORS

[Applicable to hospitals under the prospective payment system]

If base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor[1]
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658
Jan. 31, 1983	Jan. 31, 1985	1.12658
Feb. 28, 1983	Feb. 28, 1985	1.12658
Mar. 31, 1983	Mar. 31, 1985	1.12658
Apr. 30, 1983	Apr. 30, 1985	1.12658
May 31, 1983	May 31, 1985	1.12658
June 30, 1983	June 30, 1985	1.12658
July 31, 1983	July 31, 1985	1.12658
Aug. 31, 1983	Aug. 31, 1985	1.12658

[1] If a hospital's base year cost reporting period ends on a date other than as specified above, the fiscal intermediary will contact HCFA for the appropriate adjustment factor.

VIII. Impact Analysis

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that order. In addition, the Regulatory Flexibility Act (Pub. L. 96–354) requires us to prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. (For purposes of the Regulatory Flexibility Act, small entities include all nonprofit and most for-profit hospitals.) Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, show that the agency issuing the regulations has examined alternatives that might minimize unnecessary burden or otherwise ensure the regulations to be cost-effective.

Although this notice implements two regulatory provisions, its primary purpose is to publish the target rate percentages for purposes of determining the rate-of-increase ceiling for hospitals subject to our regulations at 42 CFR 405.463. The effect of the updating factors used to determine the hospital-specific portion of transition payment rates under the prospective payment system is included in the cost and impact estimates of the impact analysis of the interim rules implementing that system. Therefore, in this section, we address only the rate of increase ceiling provisions implemented through this notice.

In previous documents implementing the rate of increase ceiling, we noted that although the estimated effect of the rate of increase ceiling clearly exceeded the $100 million annual threshold of the Executive Order, we determined that impact to be caused by section 1886(b) of the Social Security Act, rather than by our regulations, now codified at 42 CFR 405.463. (See interim rules at 47 FR 43282, published September 30, 1982 and final rules in FR Doc. 83–23800, Part V of the issue of August 30, 1983. With the implementation of the prospective payment system, the rate of increase ceiling will be applied to many fewer hospitals, since hospitals paid on a prospective rate basis are not subject to the ceiling. Further, our prior estimates for the rate of increase ceiling were stated as savings in addition to savings achieved by the hospital cost limits, which will not apply to cost reporting periods beginning on or after October 1, 1983.

As established under TEFRA, the rate of increase ceiling was expected to substantially reduce Medicare expenditures for inpatient hospital services, resulting, according to our re-estimate in February 1983, in savings for the Part A Trust Fund of $480 million in Fiscal Year 1983 and $780 million in Fiscal Year 1984. However, nearly all of these savings were the result of the effect of the ceiling on hospitals that will be subject to the prospective payment system. This notice will not result in a change of Fiscal Year 1983 savings, or savings related to cost reporting periods phased in during Fiscal Year 1983. However, due to the implementation of the prospective payment system, the rate of increase ceiling will apply to only a very small proportion of Medicare expenditures for inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1983.

We estimate that only about two percent of such expenditures have been made historically to hospitals that will be excluded from the prospective payment system. However, we have not previously collected special data on these groups of hospitals, and cannot determine whether their rates of cost increase have been similar to those of hospitals as a whole. It is possible that their costs have increased significantly less rapidly than those of short-term acute-care hospitals. If this is so, then the rate of increase ceiling may have little effect on them. In any event, the savings attributable directly to the rate of increase ceiling will be much smaller than would have been attributed to the ceiling if the prospective system had not been established.

Any savings would be the direct result of implementation of section 1886(b), which clearly specifies the major features of the rate of increase ceiling. The discretionary features with respect to the ceiling, such as the decision to publish updated target rate percentages quarterly, will not have an impact of $100 million or more, or meet the other threshold criteria of the Executive Order. Therefore, we have determined that this notice is not a major rule and that a regulatory impact analysis is not required.

For similar reasons, we have determined, and the, Secretary certifies, under the Regulatory Flexibility Act, that this notice will not, in itself, result in a significant economic impact on a substantial number of small entities.

Nearly all hospitals participating in Medicare will, as a result of implementation of section 1886 of the Social Security Act, be subject to the rate of increase ceiling, the prospective payment system, or a State cost control system. As regards the rate of increase ceiling, we have exercised discretionary authority affecting the impact on small entities primarily in developing criteria for excluding certain hospitals from the prospective payment system. However, the categories for which we developed such criteria are prescribed by statute (section 1886(d)(1)(B)), and we do not believe that our criteria have resulted in subjecting a substantial number of hospitals to the rate of increase ceiling that would otherwise have been subject to the prospective payment system. Since the impact of the ceiling is attributable to the effect of the statute, rather than our regulations, we have determined that a regulatory flexibility analysis is not required.

IX. Other Required Information

A. Public Comments on This Interim Notice

Because the updating factors included in this notice will be used to implement interim rules published elsewhere in this issue of the **Federal Register**, this notice must be published on an interim basis also. We are providing a 45-day comment period on both this interim notice and the interim rules implementing the prospective payment system. We expect to respond to comments on those rules and this notice in the final rules on prospective payment. Because this is the first of a series of notices that we plan to publish quarterly, those final rules and responses to comments on this notice may not be published before the next quarterly notice. Quarterly notices will be published on an interim basis until final rules on the prospective payment system are promulgated.

Because of the large number of comments we receive, we cannot

acknowledge them individually. Although the target rate percentages and updating factors published in this interim notice will take effect as described above before the close of the comment period on [45 days from date of publication], we will review all comments received by that date and respond to them in a future publication.

B. Paperwork Reduction Act

This final notice with comment period does not contain information collection requirements that are subject to review by the Executive Office of Management and Budget under the Paperwork Reduction Act of 1980 (Pub. L. 96–21).

C. Waiver of Prior Public Comment Period and 30-Day Delay in Effective Date

The Administrative Procedure Act (5 U.S.C. 553) provides for a period of public comment and for a 30-day delay in the effective date of rulemaking documents, unless there is good cause to waive the requirements.

The target rate percentages and updating factors published in this interim notice are necessary for three purposes:

- To compute appropriate rate of increase ceilings under our regulations at 42 CFR 405.463 for hospital cost reporting periods ending during the quarter from September 30, 1983 through December 31, 1983;
- To compute appropriate rate of increase ceilings under § 405.463 for hospital cost reporting periods beginning on or after October 1, 1983 and before January 1, 1983; and
- To update the cost data used to determine the hospital-specific portion of transition payment rates under the prospective payment system.

The first purpose requires a retroactive application of percentages to cost reporting periods beginning as long ago as October 1, 1982. As explained above, we provided in the final rules concerning the rate of increase limit (FR Doc. 83–23800, Part V of the issue of August 30, 1983) that we would publish quarterly notices of target rate percentages. The purpose of quarterly publication is to ensure the availability of timely and accurate estimates. Less frequent publication (for example, annual notices of percentages, as originally provided under the interim rules published September 30, 1982) would result in accidental accrual of unintended and unnecessary advantages or disadvantages to affected hospitals, depending on how their cost reporting periods related to the publication schedule and how the percentages varied. Therefore, although generally there are no other changes in the methodology by which target rate percentages are derived, we have decided to publish revised estimates as often as feasible. (The basis for retroactive application of these estimates is explained more fully in the final rules concerning the rate of increase limit referred to above.)

Regarding the updating factors, section 604(c) of Pub. L. 98–21 provides that we must publish interim regulations and rates implementing the prospective payment system no later than September 1, 1983. These updating factors are necessary for the calculation of the transition payment rates that we will pay during the first year of that payment system.

Similarly, since the methodology used to compute the rates of increase contained in this notice is essentially the same as provided in the original interim rate of increase rules, we believe it would be inappropriate to use a different, outdated, and less accurate market basket estimate to compute rate of increase ceiling target amounts for cost reporting periods already begun. If we were required to submit the rates of increase for public comment and to provide a delayed effective date, the alternative to using these quarterly estimates would be to use the market basket estimate published September 30, 1982 for all cost reporting periods beginning before October 1, 1983.

To summarize, section 604(a) of Pub. L. 98–21, enacted on April 20, 1983, provides that the prospective payment system, to which this notice conforms and which it in part implements, is effective for cost reporting periods beginning on or after October 1, 1983. In addition, section 604(c) of Pub. L. 98–21 mandates that final rules to implement the prospective payment system be published in the **Federal Register** by September 1, 1983 without the benefit of a prior period for public comment.

For the reasons stated above, and in view of the time frames for implementation of the prospective payment system required by Pub. L. 98–21, we believe that it is not practicable, necessary, or in the public interest to publish this notice as a proposal for public comment or to provide for a delay in the effective date. However, we are offering an opportunity for comment on both this interim notice and the interim rules implementing the prospective payment system, including the amendments to the regulations governing the rate of increase ceiling.

(Secs. 1102, 1871, and 1886(b) and (d) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ww(b) and (d)); 42 CFR 405.463 and 405.474)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare-Hospital Insurance)

Dated: August 17, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 25, 1983.

Margaret M. Heckler,

Secretary.

[FR Doc. 83–23800 Filed 8–31–83; 8:45 am]

BILLING CODE 4120–03–M

federal register

Thursday
September 1, 1983

Part IV

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services; Interim Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 409, and 489

Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule sets forth the revised conditions and procedures for making Medicare payments to hospitals for inpatient services, effective with cost reporting periods that begin on or after October 1, 1983. It also contains certain provisions effective on October 1, 1983 for all providers. This rule is needed to implement the Social Security Amendments of 1983 (Pub. L. 98–21), which change the method of payment for inpatient hospital services from a cost-based, retrospective reimbursement system to a diagnosis specific prospective payment system. The new system will be phased in over a three-year period and is primarily intended to provide incentives to hospitals to manage their operations in a more cost-effective manner. The attached addendum sets forth the schedule of standardized amounts and relative weights applicable for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984.

DATES: Effective Date: In general, these regulations are effective on October 1, 1983. They will be applied with cost reporting periods beginning on or after October 1, 1983, with the following exceptions. The amendments to §§ 405.310(m), 489.21, and 489.23 will be applied for services furnished on or after October 1, 1983 irrespective of cost reporting periods. The amendments to § 405.429 will be applied for cost reporting periods beginning on or after April 20, 1983. The amendments to § 405.455 will be applied for cost reporting periods beginning on or after October 1, 1982. The amendments to §§ 405.1837, 405.1841, and 405.1877 concerning group appeals will be applied as of April 20, 1983. The amendments to § 405.453(f)(3) are effective September 1, 1983.

Comment Date: To assure consideration, comments should be received by October 17, 1983.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC–263–IFC, Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Please address a copy of any comments relating to information collection requirements to: Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, D.C. 20503, Attention: Desk Officer for HCFA.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland. When commenting, please refer to file code BERC–263–IFC.

Comments will be available for public inspection as they are received, beginning approximately three weeks after today, in Room 309–G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202–245–7890).

FOR FURTHER INFORMATION CONTACT:

Paul Olenick, (301) 594–9349; Determination of Federal Rates; Exceptions and Adjustments; Addendum

Barbara Wynn, (301) 597–1869; Determination of Hospital-Specific Rates; Excluded Costs; 602(k) Waivers; Interim Payments

Sheridan Gladhill, (301) 594–9441; Excluded Hospitals

Tom Hoyer, (301) 594–9446; Medical Review Activities; Exclusions From Coverage

George Cray, (301) 594–9755; Provider Appeals

Ed Roth, (301) 594–9437; Charges to Beneficiaries; Secondary Liability

William Morse, (301) 594–1160; Definition of and Payment for Physician Services

SUPPLEMENTARY INFORMATION:

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I. BACKGROUND

A. Medicare Reimbursement—General Discussion

The Social Security Amendments of 1965 (Pub. L. 89-97) established Title XVIII of the Social Security Act (the Act), which authorized the establishment of the Medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (Hospital Insurance) provides basic health insurance protection against the costs of inpatient hospital care and other inpatient or home health care. Part B of the program (Supplementary Medical Insurance) provides voluntary supplementary insurance covering most physicians' services and certain other

items and services not covered under Part A.

Generally, there are two bases for payment under the Medicare program. The first is "reasonable cost" and the second is "reasonable charge". Essentially, reasonable costs include all direct and indirect costs that are necessary and proper for the efficient delivery of needed health services to beneficiaries. Within this general framework, there are numerous rules regarding the reasonableness of certain categories of cost, how they are to be calculated, and how they are to be reported.

Section 1861(v)(1)(A) of the Act defines, subject to certain limitations, reasonable costs of any services as the costs actually incurred excluding any part of incurred costs found to be unnecessary in the efficient delivery of needed health services. The principles of reasonable cost reimbursement are further described and clarified in regulations in Subpart D of 42 CFR Part 405. Because actual reasonable costs cannot be determined until the end of the provider's cost reporting period, interim reimbursement amounts, approximating actual costs are determined by the fiscal intermediary serving each provider and paid to the provider throughout the year.

Providers are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Cost reports must be submitted to the intermediary on an annual basis. Upon receipt of the cost report, the intermediary makes a tentative adjustment based on the report as submitted. Final settlement is made following further review and/or audit of the cost report and records.

The second basis of payment, "reasonable charge", is for physicians' services and other medical and health services that are not furnished directly by a provider of services or by others under an arrangement with the provider. The principles of reasonable charge reimbursement are described in section 1842(b)(3) of the Act and further described and clarified in regulations at 42 CFR Part 405, Subpart E.

B. Social Security Amendments of 1972

The Social Security Amendments of 1972 (Pub. L. 92-603) contained numerous provisions affecting the Medicare program. Two sections, however, are particularly relevant to changes in Medicare reimbursement.

Section 222 of the 1972 Amendments authorized the Secretary to engage in experiments and demonstration projects in order to determine the advantages and disadvantages of making payments to Medicare providers on a prospective basis. Resulting studies on prospective payment have primarily been aimed at discovering methods of determining rates that would have long-term constraining effects on total payment without concurrently reducing quality of care.

Section 223 of the Social Security Amendments of 1972 amended section 1861(v)(1) of the Act to authorize the Secretary to set prospective limits on the costs that are recognized as reasonable under Medicare. Section 223 authorized the Secretary to apply limits to direct and indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider and to base these limits on estimates of the cost necessary for the efficient delivery of needed health services. Regulations implementing this authority are at 42 CFR 405.460. Under this authority, we published limits on hospital inpatient general routine per diem costs annually from 1974 through 1981.

C. Tax Equity and Fiscal Responsibility Act of 1982

On September 3, 1982, the President signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248. Section 101(a) of that legislation added section 1886 to the Act. This new section included two provisions that limited Medicare reimbursement for costs of inpatient hospital services. Section 1886(a) of the Act provided for the extension of the section 223 hospital cost limits, which had previously been applied only to inpatient general routine operating costs, to the total operating costs of inpatient hospital services. The expanded limits were to apply on a per discharge or per admission basis, and were to take into account the mix of types of Medicare cases treated by the hospital. Section 1886(b) of the Act provided for a new three-year limitation on payment for hospital costs that was separate from the type of limit established under section 223. This provision required that we limit for the allowable rate of increase in a hospital's inpatient operating costs per case through reductions in the amounts of reimbursement to hospitals that incur costs greater than the target amount. Section 1886(b) provided for incentive payments to hospitals that keep their costs below a target amount. The regulations implementing this provision were set forth at 42 CFR 405.463.

On September 30, 1982, we published in the **Federal Register** an interim final notice and an interim final rule that implemented sections 1886 (a) and (b) of the Act (47 FR 43296 and 47 FR 43282). The reader is referred to those documents for a more detailed explanation of the cost limit provisions and for a description of our implementation of them.

Additionally, section 101(b)(3) of Pub. L. 97-248 further required the Secretary to develop, in consultation with the Senate Committee on Finance and the House of Representatives Committee on Ways and Means, a legislative proposal for Medicare payment to hospitals, skilled nursing facilities, and to the extent feasible, other providers, on a prospective basis. In response to this requirement, the Secretary submitted, on December 27, 1982 the Department's proposal in a Report to Congress titled Hospital Prospective Payment for Medicare. A proposal on prospective payment for skilled nursing facilities will be issued in the near future.

II. SUMMARY OF TITLE VI OF THE SOCIAL SECURITY AMENDMENTS OF 1983

On April 20, 1983, the President signed Pub. L. 98-21, the Social Security Amendments of 1983. Title VI of Pub. L. 98-21 provides for Medicare payment for hospital inpatient services under a prospective payment system, rather than on a reasonable cost basis. Essentially, Medicare payment will be made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). This list contains 470 specific categories. The prospective payment rate will not include capital-related costs (e.g., depreciation, taxes, rent, etc.) or direct medical education costs, which will continue to be reimbursed under a reasonable cost-based system.

The statute provides for a 3-year transition period during which a declining portion of the total prospective payment will be based on hospitals' historical costs in a given base year and a gradually increasing portion will be based on a regional and/or national Federal rate per discharge. Beginning with the fourth year and continuing thereafter (i.e., cost reporting periods beginning on or after October 1, 1986), Medicare payment for hospital inpatient services will be determined fully under a national DRG payment methodology.

The statute excludes several types of hospitals and hospital units from the prospective payment system. These include psychiatric, long-term, children's, and rehabilitation hospitals as well as psychiatric and rehabilitation units operating as distinct parts of acute

care hospitals. Hospitals located outside the 50 States and the District of Columbia are also excluded. The excluded facilities and units will continue to be reimbursed on the basis of reasonable costs subject to the target rate of increase limits. In addition to the above categorical exclusions from prospective payment, the statute provides for other special exclusions, such as hospitals that are covered under approved State reimbursement control systems.

The Federal payment rates are determined based on the mean urban or rural standard amount per discharge. This amount is then adjusted to account for area differences in hospital wages. The standard amounts per discharge will be updated annually. For FY 84 and FY 85, the prospective payment system must be "budget neutral." That is, payments may not be greater than, nor less than, the payments that would have been paid under the law previously in effect. Beginning with FY 86, the Secretary will determine the update factor taking into consideration recommendations made by a commission of independent experts appointed by the Director of the Office of Technology Assessment.

Additional payments will be made to hospitals for discharges meeting specified criteria as "outliers". Outliers are cases that have an extremely long length of stay or unusually high cost when compared to most discharges classified in the same DRG. Additional payments will also be made for indirect costs of approved graduate medical education programs.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and non-covered services (e.g., phone, television, etc.). They may not be charged for differences between the hospital's cost of providing covered care and the Medicare payment amount.

Under the prospective payment system, payment will be made to the hospital on a per discharge basis. Therefore, hospitals may have incentives to increase admissions or reduce services. To safeguard against such practices, the statute requires the establishment of a monitoring system to review admission practices and quality of care. If an abuse of the prospective payment system is discovered (e.g., unnecessary multiple admissions of the same beneficiary or inappropriate medical practices), payment may be partially or totally denied to the hospital.

In addition to the general Medicare demonstration authority, Pub. L. 98-21 requires that certain research projects be conducted related to Medicare program costs and payment methods. The statute also requires a large number of reports to the Congress on specified areas of study, including recommendations for legislative changes.

III. MAJOR FEATURES OR PROSPECTIVE PAYMENT SYSTEM

A. Applicability

The prospective payment system will apply to all inpatient hospital services furnished by all hospitals participating in the Medicare program except for those hospitals, or units excluded as discussed below. A hospital's status as to whether it is subject to, or excluded from, prospective payment will generally be determined at the beginning of each cost reporting period and this status, for reimbursement purposes, will continue throughout the period, which is normally one year. An exception to this general rule is when a hospital comes under prospective payment after a cost reporting period has begun, or is excluded at some time during its cost reporting period because of its participation in an approved demonstration project or State reimbursement control program, or regional demonstration.

1. Excluded Hospitals and Hospital Units Subject to Rate of Increase Limits

In accordance with section 1886(d)(1)(B) of the Act, hospitals or distinct part units categorized below are excluded from the prospective payment system. Medicare will continue to pay for services furnished to inpatients of these hospitals or units on the basis of reasonable costs. These payments will, however, be subject to the rate of increase ceiling in the amended regulations at § 405.463.

a. Psychiatric Hospitals

In accordance with section 1886(d)(1)(B)(i) of the Act, hospitals that meet the definition of psychiatric hospitals in section 1861(f) of the Act are excluded from the prospective payment system. Section 1861(f) of the Act defines a psychiatric hospital as an institution that:

(i) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(ii) Satisfies the requirements of paragraphs (3) through (9) of section 1861(e) (i.e., the statutory requirements of a "hospital", which are implemented by regulations set forth at 42 CFR 405.1020 through 405.1035);

(iii) Maintains clinical records on all patients and maintains such records as the Secretary finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under Part A (i.e., meets the special medical records requirements for psychiatric hospitals set forth in 42 CFR 405.1036 and 405.1037);

(iv) Meets the staffing requirements that the Secretary finds are necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution (i.e., meets the special staff requirements for psychiatric hospitals set forth in 42 CFR 405.1038); and

(v) Is accredited by the Joint Commission on Accreditation of Hospitals.

Section 1861(f) further specifies that, in the case of an institution that satisfies the first two items above and that contains a distinct part that also satisfies the third and fourth items above, the distinct part will be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if the distinct part meets requirements equivalent to the accreditation requirements, as determined by the Secretary.

The regulations implementing section 1886(d)(1)(B)(i) of the Act are set forth at § 405.471(c)(1). Compliance with the requirements in the statute and regulations for psychiatric hospitals is demonstrated by having a provider agreement in effect to participate in the Medicare program and HCFA's assignment of a special provider number indicating participation as a psychiatric hospital. Institutions meeting the above requirements will be paid on a reasonable cost basis, subject to the rate of increase provisions of § 405.463. It should be noted, as a matter of clarification, that the distinct part referred to in the section 1861(f) definition of a psychiatric hospital is not the same as a section 1886(d)(1)(B) distinct part psychiatric unit in a general hospital (see section 1.c. below).

There are approximately 410 hospitals or distinct parts currently participating as psychiatric hospitals.

b. Rehabilitation hospitals

While section 1886(d)(1)(B)(ii) of the Act specifies that rehabilitation hospitals (as defined by the Secretary) are excluded from the prospective payment system, neither that section nor the Conference Committee report (H.R. Rep. No. 98-47, 98th Cong., 1st Sess. 193

(1983)) accompanying Pub. L. 98–21 provide explicit guidance on how the term "rehabilitation hospital" is to be defined for purposes of this exclusion. However, the report of the Committee on Ways and Means, U.S. House of Representatives, on the House bill that was considered by the Conference Committee (H.R. 1900) in recommending enactment of Pub. L. 98–21 does provide some recommendations regarding this definition (H.R. Rep. No. 98–25, 98th Cong., 1st Sess. 147 (1983)). This report states that the Committee understands that there are currently extensive rules pertaining to rehabilitation hospitals, and suggests that the Secretary use such regulations, and consult with the Joint Commission on Accreditation of Hospitals (JCAH) in order to define a rehabilitation hospital.

To comply with these recommendations, we reviewed our current regulations at 42 CFR 405.1031(d). Those regulations establish standards that must be met by rehabilitation, physical therapy, and occupational therapy departments in hospitals that participate in Medicare. (Hospitals accredited by the JCAH are ordinarily deemed to meet those requirements.) Those standards apply to all hospitals participating in Medicare that furnish rehabilitation services through the use of organized departments, without regard to the extent of the hospitals' involvement with rehabilitation. Thus, the regulations are not useful in determining the extent of a particular hospital's involvement in rehabilitation.

Moreover, we have recently proposed, in a separate **Federal Register** document, to apply new, less prescriptive requirements to all hospitals, including those that provide rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services (48 FR 299 January 4, 1983). These would apply without regard to whether the services are provided in organized departments (48 FR 299). We are currently analyzing the public comments we received on this proposal.

Because the current regulations on hospital rehabilitation services are not specific to those hospitals primarily engaged in rehabilitation, and are likely to be replaced by revised regulations in the near future, we have decided not to use those regulations as a basis for the definition of "rehabilitation hospital."

In addition, we consulted the JCAH and other accrediting bodies to identify features of their standards that could be used as a basis for our definition of rehabilitation hospitals. We have incorporated elements of these accreditation requirements in our definition. However, due to the unique nature of the prospective payment system, we found it necessary to include other criteria that are not common to the accreditation requirements. We believe the comprehensive definition that has been developed meets the legislative intent as to the application of the exclusion of rehabilitation hospitals and rehabilitation units of general hospitals from the prospective payment system.

To distinguish rehabilitation hospitals from other hospitals that offer general medical and surgical services but also provide some rehabilitation services, it was necessary to develop and include in the new regulations provisions that describe the criteria that hospitals must meet to be excluded from the prospective payment system as rehabilitation hospitals. These provisions are at § 405.471(c)(2). In summary, the criteria are as follows:

- The hospital must have in effect a provider agreement to participate in Medicare as a hospital;
- The hospital must be primarily engaged in furnishing intensive rehabilitation services as demonstrated by patient medical records showing that, during the hospital's most recently completed 12-month cost reporting period, at least 75 percent of the hospital's inpatients were treated for one or more conditions specified in these regulations that typically require intensive inpatient rehabilitation;
- The hospital must have in effect a preadmission screening procedure under which each patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment;
- The hospital must ensure close medical supervision, and furnish rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;
- The hospital must have a full-time Director of Rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law, and either has experience in the medical management of rehabilitation patients, or is Board-certified in one of a number of rehabilitation-related medical specialties;
- The hospital must have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient;
- The hospital must use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient. This must be documented by periodic clinical entries made in the patient's medical record noting the patient's status in relationship to goal attainment, and by team conferences held at least every 2 weeks to determine the appropriateness of treatment.

The first criterion that the provider have an agreement in effect to participate in Medicare as a hospital is an administrative requirement that we are imposing to ensure that hospitals are properly classified for purposes of exclusion from the prospective payment system.

We require the second criterion because we believe that examining the types of conditions for which a hospital's inpatients are treated, and the proportion of patients treated for conditions that typically require intensive inpatient rehabilitation, will help distinguish those hospitals in which the provision of rehabilitative services is a primary, rather than secondary, goal. To develop the specific list of medical conditions set forth in the new regulations at § 405.471(c)(2), and the requirement that 75 percent of a hospital's patients be treated for one or more of these conditions, we relied on HCFA Technical Assistance Document No. 24 ("Sample Screening Criteria for Review of Admissions to Comprehensive Medical Rehabilitation Hospitals/Units"). This document was developed by the Committee on Rehabilitation Criteria for PSRO of the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine.

The project that produced the sample screening criteria was funded under a purchase order with HCFA. The project built on work performed by the American Academy of Physical Medicine and Rehabilitation in 1975 under subcontract to the American Medical Association, and on the efforts of PSROs that had previously developed and implemented criteria for review of admissions to comprehensive medical rehabilitation hospitals and units. The project was intended primarily to provide a basis for reviewing the medical necessity of admission to, and continued stay in, these hospitals and units, and for assessing the quality of care furnished in them. The seven medical conditions for which sample screening criteria were developed accounted for approximately 75 percent of the admissions to comprehensive medical rehabilitation hospitals and units. These conditions are:

- Stroke;

- Dorsal or lumbar spinal cord injury with paraparesis/paraplegia;
- Cervical spinal cord injury with quadriparesis/quadriplegia;
- Congenital deformity or amputation of the leg or lower limb;
- Polyarthritic, rheumatoid, or acquired deformity of the leg or lower limb;
- Fracture of femur; or
- Head injury.

In addition, we obtained advice from the National Association of Rehabilitation Facilities (NARF) and from the American Hospital Association (AHA) regarding the types of medical conditions most often treated by hospitals and hospital units that specialize in rehabilitation. We also consulted HCFA staff physicians who had been involved in developing the Technical Assistance Document. Based on information received from these groups and physicians, we developed the list of medical conditions set forth in the new regulations at § 405.471(c).

We plan to use the second criterion as a test of whether a hospital provides specialized rehabilitation services to such an extent that it incurs costs significantly different from those of a general medical/surgical hospital and, therefore, should be excluded from the prospective payment system.

The remaining criteria for rehabilitation hospitals relate to the preadmission screening of prospective inpatients, to the types of services that must be furnished by or made available in the hospital, and to the hospital's management of the rehabilitative services it furnishes. Except for the criterion relating to a full-time director of rehabilitation, these criteria are based on similar requirements for the coverage of rehabilitation services under Medicare (see section 211 of Medicare's Hospital Manual).

In the context of these regulations, however, we plan to use these criteria, in conjunction with those described above, to determine whether particular hospitals furnish the type and intensity of rehabilitation services necessary to warrant exclusion from the prospective payment system as rehabilitation hospitals. We wish to note that we recognize that some of these criteria (e.g., the plan of treatment requirement) may also be met by hospitals in which rehabilitation is secondary to general medical/surgical treatment. However, we believe only those hospitals that primarily engage in rehabilitation could meet all of these criteria.

In addition to the general rationale set forth above, we have additional reasons for requiring each of the criteria in paragraphs (iii) through (vii) of § 405.471(c)(2).

These are as follows:

- *Preadmission screening procedure.* We believe this procedure is needed to help demonstrate that a hospital specializes in the treatment of patients who primarily require intensive impatient rehabilitation, rather than patients who primarily require medical/surgical treatment.
- *Provision of specified services.* The types of services listed are those that are typically required for the rehabilitation of patients. While some of the services listed are also available in other settings, we believe provision of all of these services would help to demonstrate that a hospital is extensively engaged in rehabilitation.
- *Director of rehabilitation.* We selected this criterion because we believe an intensive hospital inpatient rehabilitation program will require the full-time direction of a physician with special expertise in the medical management of patients who require rehabilitation services. Meeting this requirement would help a hospital to document the extent of its involvement in rehabilitation.
- *Plan of treatment.* We selected this criterion because we believe the existence of a plan of treatment for each hospital impatient who receives rehabilitation services will help to demonstrate the existence of an intensive impatient rehabilitation program. In addition, the presence of a plan of treatment in each patient's medical record would simplify the administration of the exclusion provision, since it would help HCFA or its agents determine the frequency and intensity of the rehabilitation services furnished by particular hospitals.
- *Coordinated multidisciplinary team approach.* This type of approach is currently required for the coverage of rehabilitation services. Use of this approach for all rehabilitation patients treated in the hospital would help document the primacy of rehabilitation in the hospital.

c. Distinct Part Psychiatric and Rehabilitation Units

(i) General Criteria for Distinct Part Units

Section 1886(d)(1)(B) specifies that the prospective payment system will not be applied to a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital (as defined by the Secretary). Units that qualify for this exclusion will be paid on a reasonable cost basis, subject to the rate of increase provisions of 42 CFR 405.463.

To implement this exclusion, we have developed general criteria that will apply to both types of excluded units and additional, more specific, criteria for psychiatric and for rehabilitation units, respectively. The general criteria for distinct part units are set forth in § 405.471(c)(3)(i), and are discussed in the following paragraphs. The specific criteria for psychiatric units are set forth in a new § 405.471(c)(3)(ii), and are discussed in item (ii) below. The specific criteria for rehabilitation units are set forth in § 405.471(c)(3)(ii), and are discussed in item (iii).

All excluded units must meet the general criteria in new § 405.471(c)(3)(i). The first criterion is an administrative requirement that an institution has in effect an agreement under Part 489 for participation as a hospital under Medicare. We are imposing this requirement to ensure that all units are properly classified for purposes of exclusion from the prospective payment system. The second criterion, which requires uniform application of written admission criteria to all patients, both Medicare and non-Medicare, is designed to discourage hospitals from placing patients in excluded units for reasons related to the hospital's reimbursement rather than to the type of services the patients need. We do not believe it would be appropriate for these units to be set up primarily for reimbursement reasons, rather than for reasons related to patient needs. To prevent this result, we are requiring each unit to have written policies for admission, and to apply these policies uniformly to all patients, both Medicare and non-Medicare. In addition, to ensure that all units are operated in compliance with applicable State law, we are requiring that psychiatric and rehabilitation units meet applicable State licensing laws.

The remaining criteria are administrative requirements that are necessary to enable Medicare intermediaries to distinguish costs incurred for the unit from costs of other parts of the hospital, and to measure and reimburse unit costs accurately. These criteria are based on the long standing requirements for reimbursement of separate cost entities in multiple-facility hospitals, as set forth in section 2336 of the Medicare Provider Reimbursement Manual (HCFA Pub. 15-1).

(ii) Specific Criteria for Psychiatric Units

In developing specific criteria for the exclusion of distinct part psychiatric units, we wish to ensure that the exclusion is available only to a unit that

predominantly provides psychiatric services. To identify and exclude these units, we have developed the criteria set forth in § 405.471(c)(3)(ii). Our specific reasons for selecting each of these criteria are as follows:

• *Treatment of patients with psychiatric diagnoses.* This requirement is necessary to ensure that patients are not improperly placed in the psychiatric unit for financial rather than medical reasons.

• *Direction by qualified psychiatrist.* This requirement is necessary to ensure professional oversight of policies and procedures in the unit (e.g. to assure appropriateness of admission criteria). Patients with a psychiatric diagnosis will normally require such direction. Consequently this is an appropriate identifier of this type of facility.

• *Provision of specified services: supervising nurse.* The provision of these services and use of a qualified supervising nurse is typical of units which treat patients whose characteristics are like those in psychiatric hospitals. Consequently, the provision of these services is an identifier of such a patient population.

• *Plan of treatment.* This requirement is necessary to ensure proper placement of patients. A unit which treats a patient population similar to that in a psychiatric hospital would routinely have a plan of treatment and would routinely use a multidisciplinary team approach. As such, this is an identifier of a unit whose patient population and services differ sufficiently as to warrant exclusion.

(iii) Specific Criteria for Rehabilitation Units

As in the case with the specific criteria for psychiatric units, our rehabilitation unit criteria are designed to enable us to identify those units in which the costs are sufficiently different from those of the hospitals in which the units are located to warrant exclusion of the units from the prospective payment system. We believe that the patients treated, and the types of services furnished, in units of this type are likely to be more similar to those of rehabilitation hospitals than to those of hospitals in which the primary concern is the provision of general medical/surgical services. Therefore, we are applying the same criteria in excluding rehabilitation units as in excluding rehabilitation hospitals.

d. Children's Hospitals

Section 1886(d)(1)(B) of the Act also excludes from the prospective payment system hospitals whose inpatients are predominantly individuals under 18 years of age. Generally, this includes all children's hospitals. For purposes of this exclusion children's hospital is defined at § 405.471(c)(4) of these regulations as a hospital having a provider agreement, meeting applicable requirements in subpart J, and furnishing services to inpatients who are predominantly individuals under the age of 18.

e. Long-term Hospitals

The statute (section 1886(d)(1)(B)(iv) of the Act) excludes from the prospective payment system hospitals with an average length of stay (as determined by the Secretary) greater than 25 days. The average length of stay is calculated by dividing the total number of inpatient days (excluding leave of absence or pass days) for all patients by the total number of discharges for a cost reporting period. We will make this determination based on the hospital's most recently filed cost report, except where these data may not accurately reflect a hospital's current classification. In this case, data for the most recent 6-month period will be used. Section 405.471(c)(5) of these regulations sets forth the requirements regarding long-term hospitals.

f. Hospitals Outside the 50 States and the District of Columbia

Initially, hospitals in Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Marianas will be excluded from the prospective payment system. However, the statute mandates that the Secretary complete a study before April 1, 1984, and make recommendations to the Congress regarding the possible inclusion of these hospitals.

2. Excluded Hospitals Paid Under Alternative Reimbursement Programs

Section 402 of the Social Security Amendments of 1967 (Pub. L. 90–248) and Section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) authorize demonstrations and studies for various purposes, primarily to analyze alternative methods of payment. For the most part these authorities were not altered by Pub. L. 98–21, therefore, the demonstrations and studies that are currently approved may continue unaffected.

Additionally, section 1886(c) of the Act was amended by Pub. L. 98–21 to permit approval by HCFA of State reimbursement control systems for Medicare reimbursement purposes if the systems meet certain conditions prescribed by the statute relating to applicability and administrative matters. Hospitals covered by these systems will also be excluded from the prospective payment system. The regulations implementing section 1886(c) of the Act will be published separately in the **Federal Register.**

3. Other Special Cases

Discussed below are additional special cases where the prospective payment system would be inappropriate.

a. Nonparticipating Hospitals Furnishing Emergency Services

Sections 1814(d) and 1835(b) of the Act authorize Medicare payments to hospitals not participating in the Medicare program, for emergency services (i.e., both inpatient and outpatient) provided to eligible beneficiaries under special circumstances. These statutory sections provide the basis of payment for emergency services, and Pub. L. 98–21 did not amend them. Therefore, payment for emergency services to nonparticipating hospitals will not be made under the prospective payment system. Regulations providing for payments to nonparticipating hospitals are set forth at § 405.152 and § 405.249.

b. Veterans Administration Hospitals

Veterans Administration (VA) hospitals are generally excluded from participation in the Medicare program as required by sections 1814(c) and 1835(d) of the Act. However, in some limited situations, special provisions are made for services not otherwise available in the community to be furnished by a VA hospital to the general public, including Medicare beneficiaries. When this is the case (generally for renal services) the payment mechanism will not be the prospective payment system. Rather, payment will be determined, as it has in the past, in accordance with 38 U.S.C. 5053(d).

There is authority contained in section 1814(h) of the Act, as amended by section 602(c) of Pub. L. 98–21, for applying the prospective payment system for certain hospital services provided in VA hospitals. This authority allows for payment in such circumstances to be an amount equal to the charges imposed by the VA or the prospective payment rate as established by section 1886, whichever is lower. Rather than establish a complete system by which the VA hospitals can be reimbursed under the prospective payment system for a situation which virtually never occurs, we believe the VA charges (i.e., the rates prescribed by the Secretary after consultation with the

VA Administrator) should be paid if this situation should exist.

c. Services Furnished by Risk-Basis HMOs and CMPs

At its election, a health maintenance organization (HMO) or a competitive medical plan (CMP) that receives Medicare payments on a risk basis may choose to have payment made by HCFA directly to hospitals for inpatient hospital services furnished to Medicare enrollees of the HMO or CMP. If the HMO does not exercise the option, it may negotiate its own rate with the hospital. If the HMO exercises the option, the hospital will be paid either under the prospective payment system or on a reasonable cost basis if the hospital is excluded. If the hospital is paid directly by HCFA, the payment for inpatient hospital services to Medicare HMO/CMP enrollees and administrative costs for paying hospitals directly is deducted from the Medicare capitation payments otherwise paid to the HMO or CMP.

B. Basis of Payment Under the Prospective Payment System

1. General Description

Unless excluded from prospective payment, all Medicare participating hospitals will be paid, for inpatient services provided, a specific amount for each discharge based on the case's classification into one of 468 Diagnosis-Related Groups (DRGs).

2. Discharges and Transfers

The terms "discharge" and "transfer" are defined, for purposes of prospective payment, at § 405.470(c) of these regulations. These definitions are essentially the same as they were under the hospital cost limits established as a result of TEFRA except that in cases where a patient is transferred to another hospital paid under the prospective payment system, the transfer will not be considered a discharge. A patient on a leave of absence from a hospital will not be considered discharged. In summary, a patient will be considered discharged when he or she:

- Is formally released from the hospital (Release of the patient to another hospital as described in § 405.470(c)(2) of these regulations will not be recognized as a discharge for the purpose of determining payment under the prospective payment system.);
- Dies in the hospital; or
- Is transferred to another hospital or unit that is excluded from the prospective payment system.

It was necessary to distinguish between discharges where the patient has received complete treatment and discharges where the patient is transferred to another institution for related care. The prospective payment system was intended to provide full payment, less deductibles and coinsurance, for all inpatient services associated with a particular diagnosis.

It is emphasized that discharges and transfers will be subject to medical review to assure that patients are properly categorized.

a. Transfers to Hospitals Paid Under Prospective Payment

The policy set forth in this section and contained in these regulations at § 405.470(c)(4) is intended as an interim policy. It should be noted that our ultimate goal is to pay a single rate to one hospital for a given service. Therefore, we will be reviewing discharge/transfer patterns following implementation of the prospective payment system and will revise this policy as appropriate.

When patients are transferred between hospitals receiving payment under the prospective payment system full payment will be made to the final hospital from which the patient is released. The transferring hospital will be paid a per diem for each day of the hospital stay.

The prospective payment rate paid to each hospital will be the rate specific to each hospital. That is, the rate will be composed of the Federal portion and the hospital-specific portion for each hospital. Similarly, the wage indexes and any adjustments will be those which are appropriate for each hospital, and in cases where treatment is provided under different DRGs, payment will be based on the DRG under which the patient was treated at each hospital.

Since the final discharging hospital will generally provide the greatest portion of the patient's treatment, payment to this hospital will be made at the full prospective payment rate. The transferring hospital, generally providing a limited amount of treatment to the transferred patient, is not entitled to payment at the full prospective payment rate. Therefore, payment to the transferring hospital will be made based on a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls) and the patient's length of stay at the transferring hospital. Payment to the transferring hospital may not exceed the full prospective payment rate.

Example 1: A patient stays at Hospital A for 2 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at each hospital, with an average length of stay of 10 days for the DRG. Hospital A would be paid $2,000 (2/10 × $10,000) and Hospital B would be paid $10,000, the full prospective payment rate. Total payment is $12,000.

Example 2: A patient stays at Hospital A for 8 days and is subsequently transferred to Hospital B. The prospective payment rate is $10,000 at Hospital A and $12,000 at Hospital B. The average length of stay for the DRG is 5 days. The payment to Hospital A would be limited to $10,000, the full prospective payment rate, since the length of stay exceeds the average length of stay for the DRG. Hospital B would be paid the full prospective payment rate of $12,000. Total payment is $22,000.

Example 3: A patient stays at Hospital A for 2 days under DRG X, which has an average length of stay of 10 days. The prospective payment rate is $10,000 for the hospital for X. He is subsequently transferred to Hospital B under DRG Y. The prospective payment rate at Hospital B is $16,000 for DRG Y. Hospital A would be paid $2,000 (2/10 × $10,000). Hospital B would be paid $16,000, the full prospective payment rate for DRG Y at Hospital B. Total payment is $18,000.

Example 4: A patient stays at Hospital A for 4 days under DRG X, which has an average length of stay of 8 days. The prospective payment rate at Hospital A is $16,000 for DRG X. He is subsequently transferred to Hospital B for 4 days under DRG Y which has an average length of stay of 10 days. The prospective payment rate is $10,000 for DRG Y. He is finally transferred to Hospital C. The prospective payment rate for DRG Y in this hospital is $15,000. Hospital A would be paid $8,000 (4/8×$16,000). Hospital B would be paid $4,000 (4/10×$10,000). Hospital C would be paid $15,000, the full prospective payment rate for DRG Y at Hospital C. Total payment is $27,000.

Payment to a transferring hospital is based on a per diem rate and is limited to the full prospective payment rate. Therefore, outlier payments may not be made to the transferring hospital. The criteria for making outlier determinations for the receiving hospital (i.e., the final discharging hospital) in cases involving transfers between hospitals would be the same as for any other outlier (i.e., length of stay or charges adjusted to cost for the DRG in the hospital receiving the transferred patient exceeds a certain level). In determining outlier payment in transfer cases, only the length of stay or costs in the discharging hospital, rather than combining the total period of hospitalization, will be considered.

b. Transfers to Hospitals or Units Excluded From Prospective Payment

When patients are transferred to hospitals or units excluded from the prospective payment system (e.g., psychiatric, rehabilitation, children s hospitals), the transfers will be considered discharges and the full

prospective payment will be made to the transferring hospital. Hospitals and units excluded from the prospective payment system are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (i.e., paid under the prospective payment system), and payment to both facilities would be appropriate.

When patients are transferred to hospitals that would ordinarily be paid under the prospective payment system, but, for reasons listed below, are not, payment to the transferring hospital will be a per diem amount based on the prospective payment rate for the number of days of care delivered (i.e., in the same manner as when the patient is transferred to another hospital paid under the prospective payment system). These cases are:

- When the receiving hospital is excluded from prospective payment because of participation in a statewide cost control program or demonstration; or
- When the receiving hospital's first cost reporting period (i.e., bringing it under prospective payment) has not yet begun

3 DRG Classification

A system has been developed for classifying patients into groups that are clinically coherent and homogenous with respect to resource use. Over the past several years, a case classification system called Diagnosis Related Groups (DRGs) has been developed at Yale University. The latest series of Yale DRGs is based on records of patients discharged during the last half of 1979.

Using a universe of over 1.4 million records selected from a nationally representative sample of 332 hospitals participating in the hospital discharge abstract service of the Commission on Professional and Hospital Activities, the Yale researchers created a stratified sample of 400,000 medical records, classified into 23 Major Diagnostic Categories (MDCs). Each MDC represents a broad clinical category that is differentiated from all others based on body system involvement and disease etiology. The specification of the MDCs was developed by a committee of clinicians using the following guidelines:

- Clinical consistency
- A sufficient number of patients.
- Coverage of the complete range of diagnoses represented in the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, without overlay

The patient records in each MDC were then partitioned using a classification algorithm called AUTOGRP and a prespecified set of variables to suggest subgroups of cases that were expected to be distinct in terms of length of stay. The variables used to split the MDCs were intentionally limited to those that are descriptive of the patient's clinical condition and that are readily available on most discharge abstracts, such as principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status. Suggested subgroups of cases within the MDCs were examined by physicians to determine whether the proposed distinctions were clinically sensible and whether the cases in each group were medically similar. These purely statistical subgroups were modified if they were not supported clinically.

For example, in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract), the initial statistical grouping of medical (i.e., nonsurgical) cases suggested three subgroups that were different in terms of length of stay. Each of these subgroups, however, contained several different kinds of cases (e.g., urinary tract infections, signs and symptoms, renal failure, and neoplasms). Clinical judgment suggested that the major clinical subsets of these three groups should be revised to form seven more clinically coherent initial groups: kidney stone, infection, renal failure, neoplasms, signs and symptoms, urethral stricture, and other

This process ultimately resulted in the development of the set of 470 mutually exclusive and comprehensive case classfication categories called diagnosis-related groups. Under the prospective payment system, each Medicare discharge will be classified into one of these DRGs, which are listed in section VII, Table 5, of the addendum to this document. For 468 of the DRGs, we have established weighting factors that reflect the relative resources used for furnishing inpatient services to that classification of cases. Generally, this weighting factor will be applied to determine the amount that will be paid for each DRG-discharge, regardless of the individual services furnished or the number of days of care (except for "outlier" cases discussed below). However, classification of a discharge under DRG numbers 468 through 470 require special consideration as follows:

- *DRG No. 468* represents a discharge with an operating room procedure unrelated to a given MDC. This does not necessarily represent an invalid record. For example, a patient may be admitted for cataract surgery, but have a coronary bypass operation rather than the cataract procedure, or may be hospitalized for treatment of pneumonia and be given an appendectomy during the same stay. In such instances, intermediaries will return the claims to the provider for clarification. If the accuracy of the discharge data is affirmed, the prospective payment rate will be paid as for any other DRG classification. Otherwise, the case will be reassigned to the appropriate DRG using corrected data.
- *DRG No. 469* represents discharges with a valid diagnosis in the principal diagnosis field, but not acceptable as a principal diagnosis. Examples of such cases may include a diagnosis of diabetes mellitus during pregnancy or a diagnosis of an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. In these instances, intermediaries will return the claim to the provider in order to enter the correct principal diagnosis for proper DRG assignment. The provider will resubmit the claim for payment.
- *DRG No. 470* represents discharges with invalid data. In these instances, the intermediary will return the claim to the provider for correction of data elements affecting proper DRG assignment. The provider will resubmit the claim for payment.

Because the assignment of a case to a particular DRG determines the amount that will be paid for the case, it is important that this assignment be done systematically and uniformly. Therefore, we have established an automated classification algorithm (that is, the Grouper Program) that will be used in all cases to assign discharges to their proper DRGs using essential information abstracted from the inpatient bill. The process will work as follows:

- The hospital will submit a bill for a particular case, using classifications and terminology consistent with *ICD-9-CM* and the Uniform Hospital Discharge Data Set (UHDDS) prescribed by the National Committee on Vital and Health Statistics (*Uniform Hospital Discharge Data: Minimum Data Set*, National Center for Health Statistics, DHEW Pub No. (PHS) 80—1157, April, 1980).
- The fiscal intermediary will assign a DRG to the discharge using the Grouper program.

—The Grouper program screens the essential information from the inpatient bill against the criteria that distinguish the DRGs.

—The DRG criteria include the patient's age, sex, principal diagnosis (that is, the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital), secondary diagnoses, procedures performed, and discharge status.

• If the discharge is assigned to DRG numbers 1 to 467, the intermediary will determine the appropriate prospective payment and pay the hospital.

• If the discharge is assigned to DRG number 468, 469, or 470, the intermediary will initiate appropriate special consideration, as described above.

We wish to point out that the definitions of principal diagnosis and other criteria for the UHDDS are not HCFA requirements. (Principal diagnosis is defined on page 12 of the minimum data set criteria published in April, 1980, cited above.) The UHDDS was developed for the U.S. National Committee on Vital and Health Statistics. It has been used as a standard for the development of policies and programs related to hospital discharge statistics by both governmental and non-governmental sectors for quite some time. In particular, it was used by Yale University in creating the DRG classification.

Interested parties may order the DHEW Pub. No. (PHS) 80–1157 from the Government Printing Office, and may purchase Grouper program software and ICD–9–CM DRG user manuals from the following: Health Systems International, 345 Whitney Avenue, New Haven, Connecticut 06511.

It has been suggested that the use of "principal diagnosis" and the Grouper program would in some cases result in paying a hospital based on DRG classification that does not reflect the most resource-intensive services furnished to a patient. For example, assume a hypothetical case in which a patient leaves a hospital with diagnoses A, B, C, and D. The official UHDDS definition of principal diagnosis is "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care" (*Uniform Hospital Discharge Data, Minimum Data Set*, April 1980, p. 12.). Under this standard, the patient *must be* assigned to a particular DRG, once it is determined which one of the four diagnoses caused the admission. If diagnosis A caused the admission, even though diagnosis C required the most resource-intensive treatment, the case will be assigned to a DRG related to diagnosis A.

Because of this occasional result, it has been suggested that we revise the definition of principal diagnosis, permitting hospitals to report the most-resource intensive condition of a patient as the principal diagnosis rather than the current "diagnosis established after study to be chiefly responsible for occasioning the hospitalization." Adoption of this revision presumably would result in the case being accurately assigned to a more costly DRG, yielding an appropriately greater prospective payment rate.

We have decided not to make such a change for the following reasons. First, as noted above, the definition of "principal diagnosis" is part of the UHDDS definitions. As such, it has been used to develop the current DRG classification system. (An earlier DRG system used a definition of "primary diagnosis" very similar to the proposal. This definition was one of the deficiencies in the old DRGs, as discussed in December, 1982 Report to Congress, *Hospital Prospective Payment for Medicare*, pages 66 to 75.) Second, modification as proposed of the "principal diagnosis" definition would introduce subjectivity into the process of classifying cases into DRGs. Patients with identical diagnoses could be assigned to different DRGs solely because of differing hospital and/or physician judgments as to the most resource intensive condition. This would result in our inability to definitely assign a case with multiple diagnosis to a specific DRG because of our requirement to accept the hospital's judgment as to which diagnosis was the most resource intensive.

Hospitals would determine this for us by selecting the principal diagnosis which resulted in assignment to the DRG with the highest prospective payment rate. Third, in the absence of data demonstrating relatively frequent occurrence, we question whether there are frequent multiple diagnosis cases in which the most resource-intensive diagnosis is not also the principal diagnosis. To the extent such cases do occur, we believe the costs associated with them have already been taken into account in the data base used to construct the average standardized cost amounts and the DRG relative weights. Finally, the provision of outlier payments, as required by law, will ensure additional payment in some cases in which the resources required for treatment of comorbidities and complications exceed the resources required by the principal diagnosis, and also ensures that there will be no reduction in reimbursement for cases that are unusually short lengths of stay, or for cases that are unusually inexpensive to treat. Presumably, a hospital has at least as much chance of encountering one of these cases as it does of encountering a case of the other type discussed.

Example:

To make clear the effect of our use of the "principal diagnosis" definition, let us consider the following case.

A patient age 65 is admitted for skin graft of a skin ulcer. Under normal circumstances, this case would be assigned to DRG 264, which has a weighting factor of 2.2031. However, during the stay a hip and femur procedure (except major joint procedure) is performed. Disregarding the skin ulcer, this surgical procedure would normally be assigned to DRG 211, with a weighting factor of 1.9530.

There would be an obvious inconsistency between the principal diagnosis (skin ulcer) and the operating room procedure (hip and femur procedure). In such a situation, the bill would be returned to the hospital for validation and re-verification. If the apparently inconsistent diagnosis and procedure are affirmed, this would result in the case being assigned to DRG 468 (Operating Room Procedure Unrelated to Principal Diagnosis). This DRG has a comparatively high weighting factor of 2.1037.

4. Costs Included Under the Prospective Payment System

a. Inpatient Operating Costs for Routine, Ancillary, and Special Care Services

The statute requires that the prospective payment rate serve as total Medicare payment for inpatient operating costs for all items and services furnished other than physicians' services (as defined in regulations) associated with each discharge. These include the Part A operating costs for routine services, ancillary services, and intensive care type unit services. Although we excluded the costs of malpractice insurance from the definition of total inpatient operating costs under TEFRA, these costs will be included in the definition of inpatient operating costs under prospective payment. Malpractice insurance costs allowable under the Medicare program are associated with providing inpatient care and, therefore, are included as operating costs.

We believe that by including all inpatient operating costs, the system maintains financial incentives which will permit hospitals to plan the most efficient use of resources given their unique operating circumstances. Thus, the decisions concerning the allocation of all resources rest with the managers

responsible for planning care. It is only in this manner that the most effective use of health care funds can be achieved.

b. Nonphysician Services

Other than services furnished under waivers as discussed in section c. below, effective October 1, 1983, the only services provided in an inpatient hospital setting that may be billed by an entity other than the hospital are physicians' services to individual patients reimbursable on a reasonable charge basis. (These services are defined in § 405.550(b) (published March 2, 1983 at 48 FR 8937), as discussed below. Note that physician services to providers, defined in § 405.480 (48 FR 8935), are provider services for which payment may be made only to the provider. Payment for a physician's services to the provider, rather than to an individual patient, is included in the prospective payment. These services may not be billed separately.) Therefore, all nonphysician services furnished to hospital inpatients must be payable only to the hospital regardless of whether the hospital is subject to the prospective payment system. (See Sections 1862(a)(14) and 1866(a)(1)(H) of the Act.) This includes "incident to" physician services, medical items, supplies, and services, etc. See section IV of this preamble for additional details on this provision.

c. Waivers

Section 602(k) of Pub. L. 98–21 permits waivers to be granted under special circumstances for cost reporting periods beginning prior to October 1, 1986 (the 3-year transition period), allowing continued separate direct billing under Part B by suppliers or other providers of services to hospital inpatients. This waiver is restricted to situations where this practice was in effect prior to October 1, 1982 and was so extensively used that immediate compliance would threaten the stability of patient care. If hospitals have been granted this waiver, the reasonable charges for the nonphysician services billed under Part B will be subtracted from the Part A payment amount. Hospitals that believe they would qualify and wish to request a waiver should apply to the HCFA Regional Office through their intermediary. See section V.C. of this preamble for a detailed explanation of this waiver.

5. Costs Excluded From the Prospective Payment System

Section 1886(a)(4) of the Act, as amended, excludes capital-related costs and costs of direct medical education from the definition of inpatient operating costs. Therefore, payment for these costs will continue on a reasonable cost basis.

a. Capital-Related Costs

The rules applying to capital-related costs for purposes of the prospective payment system also will apply for purposes of determining such costs under the rate of increase limit at § 405.463 and the SNF cost limits issued under § 405.460 of the regulations.

As a result, all hospitals reimbursed under Subpart D will need to identify their capital-related costs. Therefore, we are establishing in these interim final rules a new section 405.414 of Subpart D, which identifies in detail costs that are includable in a hospital's capital-related costs. Generally, the following items are treated as capital-related costs and will be reimbursed under the reasonable cost method.

- Net depreciation expense.
- Leases and rentals (including license and royalty fees) for the use of assets that would be depreciable if the provider owned them outright (except in certain cases).
- Betterments and improvements that extend the estimated useful life of an asset at least 2 years beyond its original estimated useful life or increase the productivity of an asset significantly over its original productivity.
- The cost of minor equipment that are capitalized rather than charged off to expense.
- Interest expense incurred in acquiring land or depreciable assets (either through purchase or lease) used for patient care.
- Insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.
- Taxes on land or depreciable assets used for patient care.
- For proprietary providers, a return on equity capital.

If services, facilities, or supplies are provided to the hospital by a supplying organization related to the hospital within the meaning of § 405.427, then the hospital must include in its capital-related costs, the capital-related costs of the supplying organization. However, if the supplying organization is not related to the provider within the meaning of § 405.427, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) and:

- The capital-related equipment is leased or rented by the provider;
- The capital-related equipment is located on the provider's premises; and
- The capital-related portion of the charge is separately specified in the charge to the provider.

All hospitals, whether paid under the prospective payment system or excluded, must treat capital-related costs in a manner consistent with the way identical or similar costs were treated in the base period. This is necessary since the target amount is established on the basis of a hospital's base year costs. If costs were included as inpatient operating costs for purposes of the target amount computation and considered as capital-related costs in a subsequent year, there would be an unfair and inaccurate distortion in the year-to-year comparison.

Section 603(a)(1) of Pub. L. 98–21 requires that the Secretary study, develop, and report to the Congress within 18 months after the date of enactment of Pub. L. 98–21 on proposals for legislation by which capital-related costs associated with inpatient hospital services can be included within the prospective payment amounts.

b. Direct Medical Education Costs

The direct costs (including appropriate overhead costs) of approved education programs will be excluded from prospective payment. These costs will be reimbursed separately in accordance with regulations at § 405.421. (Costs of interns and residents hired to replace anesthetists will not be included. This adjustment is being adopted to preclude reimbursement for medical education programs instituted for the purpose of maximizing medical reimbursements.) Generally, approved educational activities mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. Those programs may also include nursing schools and medical education of paraprofessionals (e.g., radiologic technicians). These programs do not include on-the-job training or other activities which do not involve the actual operation or support except through tuition or similar payments of an approved education program. Also, they do not include patient education or general health awareness programs offered as a service to the community at large.

6. Cost Reporting Periods

Hospitals subject to prospective payment will be paid under the new payment system for inpatient services effective with the hospital's first cost reporting period beginning on or after

October 1, 1983. The appropriate blend of the hospital's target amount and the DRG-rate will be paid for each discharge occurring on or after the first day of the cost reporting period. It is likely that a number of patients will be admitted and receive services before the beginning of the new period, but will be discharged after the period begins. Because the prospective payment rate is intended to cover an entire hospital stay, this situation would result in duplicate payment for a portion of the inpatient stay. Section 604(b) of Pub. L. 98-21 requires that, in this situation, an appropriate reduction in the prospective payment rate will be made to take into account amounts payable for items and services furnished before the cost reporting period begins. Therefore, the amounts payable on a reasonable cost basis for the portion of a hospital stay occurring before the beginning of the first cost reporting period on or after October 1, 1983 (i.e., the effective date for prospective payment) will be subtracted from the prospective payment rate for the applicable discharge. However, the prospective payment rates will not be reduced below zero; that is, if reasonable cost payments exceed the prospective payment rate, no additional payment will be made but pass through costs will not be reduced.

Section 604(a)(1) of Pub. L. 98-21 states that a change in a hospital's cost reporting period made after November 1982 will be recognized, for purposes of the effective date of the prospective payment system, only if the Secretary finds good cause for the change. We are implementing this requirement through regulations at § 405.453(f)(3), which are effective for cost reporting periods ending on or after the date of publication of these interim rules. We considered applying this requirement to all changes since November, 1982. However, a number of hospitals have had changes approved for cost reporting periods that have already closed. We decided that retroactive application of the requirements of § 405.453(f)(3) was not feasible, but that making them effective as soon as possible was necessary, since we did not wish to afford hospitals an additional 30-day or more period in which to effectuate such changes before the rules take effect. Therefore, even if our fiscal intermediaries have approved such changes, we will not recognize them for purposes of a hospital's entry into the prospective payment system unless the period for which the change is approved has already closed. Under this policy, a hospital will be required to adhere to the cost reporting period initially selected unless a change is authorized in writing by the hospital's fiscal intermediary.

To establish good cause for a change, the hospital must show that there are specific circumstances that support its request for the change. The hospital's written request must be received by the intermediary 120 days prior to the reporting period to be changed. Good cause would be found to exist, for example, if a hospital that is part of a multi-hospital system requests that its cost reporting period be changed to coincide with the periods used by all other components of the system. However, good cause would not be found to exist where the effect of the change is to change the date by which the provider becomes subject to, or is excluded from, the prospective payment system.

7. Publication of Standardized Amounts and Relative Weights

a. Initial Rates

Section 604(c) of Pub. L. 98-21 requires that a notice of the interim final DRG prospective payment rates effective with cost reporting periods beginning on or after October 1, 1983, be published in the **Federal Register** no later than September 1, 1983. Additionally, while a period for public comment is required, the rates as published will be effective on October 1, without consideration of comments received. However, by notice published in the **Federal Register** not later than December 31, 1983, the payment amounts must be affirmed or modified after consideration of those comments. Section 604(c) also requires that if a modification is made reducing payment rates, this modification will apply only to discharges occurring after 30 days from the date the notice of modification is published in the **Federal Register**. The above requirements are included in regulations at § 405.470(d)(1).

b. Annual Publication of Standardized Amounts and Relative Weights

Beginning in 1984, HCFA will publish in the **Federal Register** annual notices setting forth amounts and factors necessary to determine prospective payment rates applicable to discharges occurring during the Federal fiscal year. See the regulations at 405.470(e)(2) that establish dates by which the notices will be published.

C. Determination of the Prospective Payment Rates

This section contains a detailed explanation of how the final DRG-based prospective payment rates are determined, adjusted, and updated. An explanation of applicable rates during the 3-year transition period is presented in section C.4. of this preamble.

1. Calculation of Adjusted Standardized Payment Amounts

The statute requires that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services. The methodology for arriving at the appropriate rate structure is essentially prescribed in the Act in section 1886(d)(2). It requires that certain base period cost data be developed and modified in several specified ways (i.e., inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation. Table 1, section VII of the addendum contains the 18 regional standardized amounts (further divided into labor/nonlabor portions). The national standardized amounts are not included in the table because, for FY 84, Federal rates are based on regional averages. (In FY 85, Federal rates will be based on a combination of regional and national averages.) For the interested reader, the national standardized amounts for FY 84 have been calculated to be $2,837.91 as the urban average ($2,206.22 for the labor share and $631.69 for the nonlabor share) and $2,264.00 as the rural average ($1,847.42 for the labor share and $416.58 for the nonlabor share). These amounts are only estimates that, for comparison purposes, have been computed in the same manner as the regional amounts contained in Table 1 section VII of the addendum.

a. Base Year Cost Data

Section 1886(d)(2)(A) of the Act requires that, in determining allowable costs for the base period, the most recent cost reporting period for which data are available be used. Therefore, we have used Medicare hospital cost reports for reporting periods ending in 1981.

In calculating standardized amounts, we gathered cost reports from nearly all hospitals participating in Medicare, manually extracted necessary information, and prepared the information in computer-readable form. Because this process required a great deal of staff time, there was considerable lag time between the filing

of cost reports and the availability of complete data for use by HCFA. Thus, calendar year 1981 cost data were the most recent cost reporting period data available for use.

As explained in section III.B. of this preamble, prospective payment is intended to cover all hospital inpatient operating costs for treating Medicare beneficiaries. The base year cost data include all allowable hospital costs incurred in treating Medicare patients except, to the extent possible, the following:

(i) Costs from psychiatric, rehabilitation, children's, and long-term hospitals, and subproviders;

(ii) Capital-related costs, as recorded in the depreciation cost centers of the Medicare cost reports and return on equity capital, if applicable;

(iii) Direct medical education costs;

(iv) Nursing differential costs, which were previously reimbursable but are now disallowed under section 1861(v)(1)(J) of the Act, effective with services furnished on or after October 1, 1982. (The reported hospital operating costs were adjusted to reflect a zero nursing salary differential.)

Since only Medicare allowable inpatient operating costs were used in the data base, routine costs in excess of the routine cost limits provided for in section 223 of Pub. L. 92-603 were not included in the calculation of the standardized amounts.

The resulting Medicare cost was then divided by the number of Medicare discharges during the year, resulting in total Medicare allowable inpatient operating costs per discharge, for each hospital included in the data base. To determine discharges we relied on a monthly tabulation of Medicare discharges covering the same periods represented in the cost report. These final amounts represent the base year cost data.

b. Updating for inflation

Section 1886(d)(2)(B) of the Act requires that the base year cost data be updated. This requires a two-step process.

(i) The base year cost data, representing allowable costs per Medicare discharge (per hospital), are inflated through fiscal year 1983 using actuarial estimates of the rate of increase in hospital inpatient operating costs nationwide. The estimated actual rates of inflation for the hospital industry are as follows:

Calendar year	Inflation rate (percent)
1981	15.9
1982	15.0
1983	11.7

(ii) The resulting amounts are further inflated through fiscal year 1984 by using the estimated annual rates of increase in the hospital market basket, plus 1 percentage point, in accordance with section 1886(b)(3)(B) of the Act. (See the notice of target rate percentages published elsewhere in this issue of the **Federal Register.**)

Since July 1, 1979, the hospital cost limit schedules have incorporated a "market basket index" to reflect changes in the prices of goods and services that hospitals use in producing general inpatient services. We developed the current market basket by identifying the most commonly used categories of hospital inpatient operating expenses and by weighting each category to reflect the estimated proportion of hospital operating expenses attributable to each category. We then obtained historical and projected rates of increase in the resource prices for each category. Based on the rate of increase and the weight of each category, we developed an overall annual rate of increase in the hospital market basket. The categories of expenses used to develop the revised market basket are based primarily on those used by the American Hospital Association in its analysis of costs, and by the U.S. Department of Commerce in publishing price indices by industry.

In developing the market basket index used in establishing the prospective payment rates, we have revised in two ways the market basket previously used under the hospital cost limits, which were published in the **Federal Register** (47 FR 43313) on September 30, 1982. First, we have added malpractice insurance to the categories of expenses included in the market basket. We made this change because malpractice insurance premiums, which were excluded from the hospital cost limits, are included in the prospective payment rates. Second, we have revised the proportions assigned to each expense category to reflect the estimated proportion of total inpatient operating costs, including malpractice insurance attributable to each category.

The price variables used to predict price changes for each category of expenses are specified in Table 2, section VII of the attached addendum. For further background on the development of the market basket index, see Freeland, Anderson and Schendler, "National Hospital Input Price Index", *Health Care Financing Review*, Summer 1979, pp. 37-61.

c. Standardization

Section 1886(d)(2)(C) of the Act requires that each hospital's updated base year cost per discharge be standardized. Standardization means the removal of the effects of certain variable costs from the cost data.

i. Variations in Case Mix Among Hospitals

Section 1886(d)(2)(c)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (i.e., the case-mix index) is similar to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). Essentially, a case-mix index has been calculated for each hospital (based on 1981 cost and billing data) reflecting the relative costliness of that hospital's mix of cases compared to a national average mix of cases. Standardization, necessary to neutralize the effects of variations in case mix among hospitals, is accomplished by dividing each hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3, section VII of the addendum contains the case-mix index values used for this purpose.

While the case-mix indexes used to develop the prospective payment rates are similar to those previously published (see 47 FR 43314), they differ in one respect. The weights used in their construction are not limited to the DRGs represented in the 1981 MEDPAR data set. The case-mix indexes have been calculated using weighting factors derived for all DRGs. Section III.B.3. of this preamble contains an explanation of the development of the DRG weighting factors. We computed each hospital's case-mix index by multiplying the weighting factor for each DRG by the number of MEDPAR cases classified in that DRG and dividing that result by the hospital's total number of MEDPAR discharges.

ii. Indirect Medical Education Costs

After adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix complexity, we divided each cost by 1.0 plus the product of double the education adjustment factor (11.59 percent) and the individual hospital's adjusted intern-and-resident to bed ratio. (Section III.D.4. of this preamble contains a

detailed explanation of the education adjustment factor and ratio.) We determined that adjusted ratio by dividing the number of FTE interns and residents for the cost reporting period to which the average cost per discharge applies by the hospital's bed size determined at the beginning of that period to obtain the hospital's intern-and-resident to bed ratio, and dividing that ratio by .1. In order to appropriately standardize base year data for indirect medical education costs, it is necessary to use the same education adjustment factor in standardization as is used in making additional payments to teaching hospitals. Since the statute requires that the education adjustment factor be doubled in determining the amount of additional payments, we must also double the factor for standardization.

Example: After adjusting for inflation and standardizing for case-mix, the cost per discharge of a hospital with 686 beds available for use in Queens County, New York, is $1646.09. The hospital employed 77 FTE interns and residents in approved teaching programs.

The cost per case is adjusted for education costs as follows:

77 divided by 686 = .11224, which is the intern-and-resident to bed ratio for this hospital.

.11224 divided by .1 = 1.12240—Adjusted Ratio.

$1646.09 divided by [1 + (.1159 × 1.12240)] = $1456.61, Education-adjusted cost per discharge.

iii. Adjustments for Variation in Hospital Wage Levels (Federal Portion)

Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for area variations in the hospital wage levels. This adjustment requires the division of the average cost per discharge into labor-related and nonlabor-related portions. To determine the labor-related portion, we summed the percentages of the labor-related items (i.e., wages and salaries, employee benefits, professional fees, business services, and miscellaneous items) from the market basket. Using the most current market basket, the labor-related portion is 79.15 percent. Under the operating cost limits, the labor-related portion equaled 80.77 percent.

However, as mentioned in section C.1.b. of this preamble, the market basket applicable for the prospective payment system has been revised to include malpractice insurance. Therefore, the resulting labor-related percentage has also been revised.

To remove the effects of local wage differences from hospital costs, the labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located. The wage index reflects the average hospital wage level in the geographic area in which the hospital is located compared to the national average. The index is calculated based on wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor. Specificially, the source file is the 1981 ES 202 Employment, Wages, and Contributions File for hospital workers (Standard Industrial Classification code 806).

The data used to develop the wage index were supplied by BLS, and are the most reliable national data available. If we discover that we, or BLS, have made any error that results in an incorrect wage index for any area, we will direct the Medicare intermediaries to recalculate the payment rates. However, BLS has advised us that they are unable to correct any inaccuracies in the wage index that may result from a hospital's failure to report the required wage and employment data. Moreover, any revisions in wage indexes will only apply to the adjustment of the standardized amounts as described in section C.2.a. of this preamble. We will not recalculate the standardized amounts themselves based on revised wage indexes.

In developing the wage index, we used approximate values for certain areas because BLS confidentiality requirements prohibit the disclosure of actual data or indexes for areas that include fewer than three reporting units. (A reporting unit is the smallest unit for which data are recorded on the employer's contribution report. Therefore, two or more hospitals owned by one organization could appear as one reporting unit.) The BLS has identified the areas having wage index values closest to, but not less than, the wage index for those areas where actual disclosure is prohibited. Additionally, data from Federal hospitals (e.g., VA hosptials) are excluded in determing wage indexes because these hospitals typically use national pay scales. Therefore, the amounts paid to employees do not necessarily reflect area wage levels.

Previously, we have published wage indexes for each Standard Metropolitan Statistical Area (SMSA), New England County Metropolitan Area (NECMA), and State rural area. On June 30, 1983, the Executive Office of Management and Budget (EOMB) began using Metropolitan Statistical Areas (MSAs) in lieu of SMSAs (see section III.C.1.d. of this preamble).

An example of standardization for wages follows:

Assume a hospital has an average cost per Medicare discharge of $3,000 and the wage index for the area is 1.0293.

$3000 × 79.15% (labor-related portion) = $2374.50 (labor share).

$2374.50 = $2306.91 (wage adjusted labor share) 1.0293.

The wage indexes are listed in Table 4, section VII of the addendum.

iv. Cost-of-Living Factor for Alaska and Hawaii

Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost-of-living in the States also affects the cost of nonlabor items (e.g., supplies and equipment). Under the Amendments, hospitals in Alaska and Hawaii will be entitled to an increased prospective payment rate because of the generally higher cost of living in those States. The effect of this higher cost of living is to increase Alaska and Hawaii hospital nonlabor costs from the levels generally prevalent in the rest of the country. Therefore, we believe it is desirable to reduce, as much as possible, the effect of the higher nonlabor costs in deriving each hospital's standardized cost per discharge. Accordingly, we divided the nonlabor-related portion of the average Medicare cost per discharge for hospitals located in Alaska and Hawaii by an appropriate cost-of-living adjustment factor. We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act. The adjustment factors contained in the table below are based on data obtained from the U.S. Office Of Personnel Management as published in their FPM-591 letter series.

Table.—Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska: All areas	1.25
Hawaii:	
Oahu	1.20
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.10

As explained above, the average labor-related portion of hospital costs (i.e., based on the market basket) equals 79.15 percent of total costs. Therefore, the nonlabor portion equals 20.85 percent. The formula used to make the standardization adjustments for the nonlabor related costs in Alaska and Hawaii is as follows:

$$\frac{(\text{Average Cost Per Medicare Discharge}) \times (20.85\%)}{(\text{Cost-of-Living Adjustment Factor})}$$

d. Urban/Rural Averages Within Geographic Areas

Section 1886(d)(2)(D) of the Act requires that average standardized amounts (i.e., per discharge) be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. The statute further specifies that the term "urban area" means an area within a Standard Metropolitan Statistical Area (SMSA), as defined by EOMB, or within such similar area as the Secretary has recognized by regulation. The term "rural area" means any area outside of urban areas.

On June 30, 1983, EOMB began using Metropolitan Statistical Areas (MSAs) in lieu of SMSAs. MSAs are designated and defined following a set of new standards prepared by the Federal Committee on MSAs, which advises EOMB on metropolitan area definitions. Under these standards, an area qualifies for recognition as an MSA in one of two ways: (1) if a city of at least 50,000 population is located in the area, or (2) if it is an urbanized area of at least 50,000 with a total metropolitan population of at least 100,000. In addition to the county containing the main city, an MSA may also include additional counties that have close economic and social ties to the central county. MSAs are defined in terms of entire counties, except in the six New England States. In most cases, there is little difference between the SMSA designations and the MSA designations beyond the change in title. For example, the Los Angeles SMSA is now the Los Angeles MSA. Therefore, we are using MSA designations for purposes of the prospective payment system because this is the classification system currently used by EOMB, and the new designations recognize area changes reflecting 1980 census data. The MSA designations announced by EOMB on June 27, 1983 and effective June 30, 1983 are contained in Table 4, section VII of the addendum.

Section 601(g) of Pub. L. 98–21 requires that any hospital located in New England will be classified as being in an urban area if the hospital was classified as being in an urban area under the classification system in effect in 1979. As a result of this provision, the following counties are deemed to be urban areas: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

As a result of the adjustments explained above, we have calculated 18 average adjusted standardized amounts per Medicare discharge. In summary, these amounts: are adjusted for inflation; are standardized to remove the effects of area wage differences, indirect medical education, case mix, and cost-of-living in Alaska and Hawaii; and are grouped by urban/rural and geographic designations.

e. Calculation of Adjustments to Standardized Amounts

The various calculations explained in the sections above resulted in a determination of 18 separate average standardized amounts. These amounts were further adjusted taking into consideration various provisions of Pub. L. 98–21.

i. Part B Costs

As explained above, the prospective payment rates are intended to cover all costs associated with inpatient hospital services for Part A beneficiaries except physicians' services to individual patients. Because many of these services have previously been billed under Part B of the program, the standardized costs per discharge do not include these amounts.

Section 602(e) of Pub. L. 98–21 added section 1862(a)(14) to the Act to prohibit payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital or furnished by an entity under arrangements (as defined in section 1861(w)(1) of the Act) made by the hospital. Section 1861(w)(1) of the Act defines the term "arrangements" as "arrangements under which receipt of payment by the hospital (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title discharges the liability of such individual or any other person to pay for the services." Because the term "arrangements" is defined in a way that satisfies all beneficiary liability for the services (except for the Part A cost-sharing provisions), Part B billing by an entity other than the hospital for nonphysician services furnished to hospital inpatients is essentially prohibited, effective October 1, 1983. This prohibition applies to all hospitals participating in the Medicare program, not just those subject to prospective payment.

In order to adjust the standardized amounts per discharge so that the Federal rate payable in FY 84 includes an approximation of costs previously billed under Part B, they must be increased based on estimates that have been made by HCFA's Office of Financial and Actuarial Analysis.

Since 1980 and 1981 data are used to set the prospective payment rates, the estimated amounts for inpatient services billed to Part B of Medicare should be consistent with policies and practices existing in 1980 and 1981. The amounts for inpatient services billed to Part B were derived from Part B billing data and then projected to FY 1984 consistent with estimated-growth and with 1980–81 policies and practices. (Most of those amounts are attributable to lab tests sent out to independent labs.) The effect of the hospital based physician regulations is excluded from this adjustment since section 1886(d)(5)(D) specifies adjustment only for the effects of section 1862(a)(14). The projections of the FY 84 amounts were divided by HCFA's estimate of FY 84 Medicare inpatient costs to derive the adjustment factor of 0.13%. Therefore, the standardized amounts have been increased by this percentage. Because section 1886(d)(5)(D)(ii) provides that an adjustment to the Federal payment rates will be made in each fiscal year for nonphysician inpatient hospital services previously billed under Part B, we will estimate the amount of this percentage adjustment to the standardized amounts on an annual basis.

ii. FICA Taxes

Section 102 of Pub. L. 98–21 requires that certain hospitals (i.e., non-profit organizations) enter the Social Security system and begin paying FICA taxes for employees beginning January 1, 1984. Section 1886(b)(6) of the Act is also amended by Pub. L. 98–21, requiring that adjustments be made in the rate of increase base period costs in recognition of these higher payroll costs. The conference committee report accompanying Pub. L. 98–21 expressed the intent that the Federal rate also be adjusted to reflect this change. (H.R. Rep. No. 98–47, 98th Cong. 1st Sess. 184 (1983).) Our actuaries have estimated the amount of the adjustment to the

standardized amounts necessary to account for increased payroll taxes for hospitals entering the Social Security system.

The Office of the Actuary (OACT) in the Social Security Administration (SSA) supplied us with an estimate of the 1984 payroll of non-profit hospitals not covered by the FICA tax in 1981. IRS data were combined with SSA internal data to identify which of the health services employers with fifty or more employees were not covered by the FICA tax 1981. (Since hospitals are not identified in the data, health services employers with fifty or more employees are used as a proxy.) The OACT estimated that the 1984 payroll for hospitals not covered by FICA in 1981 was about $2.7 billion.

The $2.7 billion payroll was multiplied by 87% to derive the inpatient share and further multiplied by 36% to derive Medicare's share of the inpatient share. The result was multiplied by the 1981 FICA tax rate of 6.65% to derive Medicare's share of the employer portion of the FICA taxes. Medicare's share of the FICA taxes was divided by the 1981 Medicare hospital costs to derive the adjustment factor of 0.18%. Therefore, the standardized amounts were increased by this percentage.

The 87% ration of inpatient costs to total costs was derived from American Hospital Association data and verified by analysis of Medicare hospital cost report data. The 36% Medicare share of inpatient cost was derived from analysis of Medicare hospital cost reports for non-profit—non-government hospitals.

iii. Outliers

Section 1886(d)(5)(A) of the Act requires that payments, in addition to the basic prospective payment rates, be made for discharges involving day or cost outliers as explained in section III.D.1 of this preamble. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect additional payments for outlier cases.

The statute further requires that outlier payments may not be less than 5 percent or more than 6 percent of total payments projected to be made based on the prospective payment rates in any year. In accordance with this requirement, we estimate that outlier payments for FY 84 will be 6.0 percent of total payments (including both prospective and outlier payments). Therefore, we have reduced the standardized amounts by multiplying by .943, which is a factor computed to achieve the result. Prior to each fiscal year, an estimate of outlier payments for that year will result in an adjustment to the standardized amounts used in calculating Federal rates. The methodology for determining the adjustment factor needed to actualize that estimate is closely related to the method for determining the budget neutrality adjustment factor discussed in the next section, and is explained in section VIII of the addendum along with the derivations of the budget neutrality adjustments.

iv. Budget Neutrality

Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that projected aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. Similarly, section 1886(e)(1)(B) of the Act requires that projected aggregate reimbursement for the Federal portion of the prospective payment rates should equal the corresponding share of estimated amounts payable prior to the passage of Pub. L. 98–21. Thus, for FY 84, 75 percent of projected payment for inpatient operating costs based on the hospital-specific portion should equal 75 percent of the amount projected to be payable for inpatient operating costs under the law in effect before enactment of Pub. L. 98–21. Likewise, total estimated prospective payments incurred deriving from the 25 percent Federal portion, including outlier payments and adjustments and special treatment of certain classes of hospitals, should equal 25 percent of projected payments incurred under the prior reasonable cost reimbursement system. (Note that this does not apply to payments such as payments of a return on equity capital, made in addition to prospective payments.)

This adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs (for FY 84 and FY 85) that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98–21.
- *Step 2*—Multiply total incurred payments by 25 percent (for FY 84) and 50 percent (for FY 85), i.e., the Federal portions of the total payment amounts for each year.
- *Step 3*—Estimate Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments made under the special treatment provisions of § 405.476 (e.g., outliers, indirect medical education) to the Federal portion.
- *Step 5*—The difference between amounts calculated in Step 4 and Step 2 is divided proportionally among the standardized amounts resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the FY 84 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (for example, psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above. For a more detailed explanation of budget neutrality, see section VIII of the addendum.

f. Summary of Calculations Resulting in Adjusted Standardized Amounts

In summary, we began our calculations by developing base year cost data for individual hospitals; we updated these amounts to account for inflation through fiscal year 1984; we standardized the data; we grouped the data from individual hospitals resulting in average standardized amounts for urban and rural hospitals located in the nine census divisions; and we adjusted the resulting 18 standardized amounts in accordance with requirements of the Act. Throughout the remainder of this discussion, when we refer to "adjusted standardized amounts", we are referring to the 18 separate average amounts calculated as described above.

2. Adjustments for Area Wage Levels and Cost-of-Living in Alaska and Hawaii

This section contains and explanation of two types of adjustments that will be made by the fiscal intermediaries to the adjusted standardized amounts. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and non-labor portions. See Table 1, section VII of the addendum, which contains the actual divided amounts which will be used for calculation of prospective payment rates.

a. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional Federal rates to account for area differences in hospital wage levels. This adjustment will be made by the fiscal intermediaries by multiplying the labor-related protion of the adjusted standardized amount (i.e., 79.15 percent of the total amount) by the appropriate wage index for the area in which the hospital is located. The wage indexes, applicable for fiscal year 1984, are presented in Table 4, section VII of the addendum.

b. Adjustment for Cost-of-Living in Alaska and Hawaii

As explained in section III.C.1.c.iv. of this preamble, the statute provides for an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment explained in section a. above. The adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the fiscal intermediaries by multiplying the nonlabor portion (i.e., 20.85 percent) of the standardized amounts by the appropriate adjustment factor contained in the table in section III.C.1.c.iv.

3. Federal DRG Prospective Payment Rates

a. DRG Classification

As explained in section III.B. of this preamble, all Medicare discharges will be classified according to one of 467 DRGs. (Note that DRG No. 468 may also be assigned when valid discharge records contain an operating room procedure unrelated to the Major Diagnostic Category.)

b. Weighting Factors

The actual DRG Federal payment rates are determined by multiplying the standardized amounts by weights appropriate to each discharge. These weights are intended to reflect the relative resource consumption associated with each DRG. That is, each weight reflects the relative cost, across all hospitals, of treating cases classified in that DRG. To establish these weights, we used data from the MEDPAR file (MP) (a statistical file containing coded clinical information and billed charge data based on a 20 percent sample of all Medicare claims), from the Medicare cost reports (MCR), and from non-MEDPAR discharge records for Maryland and Michigan hospitals (NMP). Maryland and Michigan discharge records were used to calculate the weights for 109 DRGs that either contained no MEDPAR cases or had too few cases to provide a reasonably precise estimate of the average cost of care. Because the prospective payment system requires the establishment of a rate for all DRGs, Maryland and Michigan records were used to calculate the weighting factors for DRGs which were not prevalent in the 1981 MEDPAR file. Discharges falling within the 109 DRGs for which non-MEDPAR records were used to construct the prospective payment weighting factors represent less than .3 percent of all Medicare discharges.

In addition, of the 468 categories which required the determination of prospective payment weighting factors, the DRG assignment program (i.e., the MEDPAR grouper) collapsed 25 into 16 more general categories because specific clinical information essential for the assignment of Medicare discharges to these DRGs was not available in the MEDPAR data set. For example, DRGs 106 and 107, corresponding to coronary bypass with and without cardiac catheterization, are not distinguished in the MEDPAR file. Instead, there is a single group (labeled DRG 107) containing coronary bypass patients with or without catheterization. To derive prospective payment weighting factors for DRGs that had been combined in the MEDPAR data set, we relied on the same non-MEDPAR discharge records from Maryland and Michigan used to construct the weights for the 109 empty or low volume DRGs.

Based on the Maryland and Michigan records, we first computed weighting factors for all 468 categories. For example, assume relative weights for DRGs 106 and 107 as shown in the following table:

DRG	Maryland	Michigan
106	1.3862 (30)	1.2418 (80)
107	1.4722 (20)	1.3162 (50)

The numbers in parentheses represent the number of discharges on which each weight is based. The weighting factor for DRGs 106 and 107 combined (i.e. weighted by the number of discharges in each DRG) is 1.3121.

We then divided the weighting factor for the combined DRGs in the MEDPAR data set by the combined Maryland-Michigan weight for the corresponding DRGs to yield an adjustment ratio. Using our hypothetical example, if the weighting factor for DRG 107 in the MEDPAR file (representing DRGs 106 and 107 combined) is 1.2600, we computed the adjustment ratio 1.2600 divided by 1.3121 or .9603. We then multiplied all of the original Maryland and Michigan weighting factors by this ratio. Using our example, the revised weights would be:

DRG	Maryland	Michigan	Combined
106	1.3312 (30)	1.1925 (80)	1.2303
107	1.4138 (20)	1.2639 (50)	1.3067

The combined column, the weighted average of the adjusted original State weights, represents the weighting factors for the MEDPAR DRGs that were collapsed or otherwise combined. Thus, in our example the hypothetical prospective payment weighting factors for DRGs 106 and 107 would be 1.2303 and 1.3067, respectively.

The calculation below illustrates the use of the data in constructing the weighting factors. The source of the data items is given in parentheses for each step of the calculation.

i. Computation of Adjusted Cost for Each Case

To derive DRG weights, we first calculated an adjusted cost for each case by: (1) Multiplying the number of days the patient spent in a regular room (MP or NMP) by the hospital's routine cost per day (MCR); (2) Multiplying the number of days the patient spent in a special care unit (MP or NMP) by the hospital's special care unit cost per day (MCR); and (3) Multiplying the ancillary charges for services to the patient (MP or NMP) by the relevant departmental ancillary cost to charge ratios (MCR) to determine the cost of ancillary services. All hospital routine and special care per diem costs were standardized to July 1, 1981 to coincide with the mid-point of the period represented in the MEDPAR file (i.e. calendar year 1981 records). Example 1 depicts the hypothetical calculation of the adjusted cost per case for a patient who spent 10 days in a hospital in New York City. Two of the 10 days were spent in a special care unit. During the stay, the patient incurred charges for radiology, laboratory and pharmacy services.

EXAMPLE 1.—Calculation of Adjusted Cost Per Case for Cases Classified Within a DRG

Routine care cost per diem (MCR)	×	Routine care days (MP or NMP)	=	Routine care cost
$150		8		$1,200

Special care cost per diem (MCR)	×	Special care days (MP or NMP)	=	Special care cost
$200		2		$400

Ancillary department	Cost to charge ratio (MCR)	×	Ancillary charges (MP or NMP)	=	Ancillary cost
Radiology	$0.80		$55		$44
Laboratory	.85		175		149
Pharmacy	1.20		80		96
Total					289

NOTE.—Adjusted Cost Per Case $1,200 + $400 + $289 = $1,889.

ii. Standardization of Adjusted Cost Per Case for Variation Due to Teaching Activity and Hospital Wage Levels

The next step was to standardize each adjusted cost per case for the effects of variations in the level of hospital specific teaching activity and area-specific hospital wage levels, so that the cost values would be comparable across hospitals. The method for standardizing adjusted costs per case for differences in teaching activity is as follows. First, for each hospital with an approved internship and residency program, we determine the ratio of full-time equivalent (FTE) interns and residents per bed. We compute this ratio for each hospital from data contained on Medicare institutional certification surveys where available, and from data submitted directly by the intermediary. We then multiply the FTE intern and resident to bed ratio by 5.795 percent, the indirect education cost adjustment factor, and add the product to 1.0. This results in a teaching activity adjustment factor which we then use to divide the hospital's adjusted cost per case. The result of this division is a cost value for each case adjusted for hospital differences in teaching activity.

Next, we divided each hospital's adjusted cost per case into labor related and non-labor components. The labor related component was derived from the market basket and represents a fixed share (79.15 percent) of cost per case. This share represents the sum of the 1981 market basket relative importance weights for wages and salaries, employee benefits, professional fees, business services, and miscellaneous expenses (see Table 2, section VII of Addendum). The labor related component of adjusted cost per case was then divided by the hospital's applicable wage index from Tables 4A and 4B. This result was added to the non-labor component of the adjusted cost per case to yield a revised cost per case that is standardized for hospital differences in teaching activity and area wage levels. The resulting adjusted cost values for the cases from each hospital represent estimates of the treatment costs that would prevail if the hospital had no teaching programs, and paid the prevailing national average wage rates. Example 2 depicts the hypothetical calculation of this standardized cost per case.

Example 2

Calculation of Standardized Cost Per Case
Adjusted cost per case = $1889
Hospital intern and resident to bed ratio (based on 686 bed facility with 77 FTE interns and residents)
(77 divided by 686) divided by .1 = 1.1224
Education adjustment factor = 5.795 percent
Adjusted cost per case, standardized for differences in teaching activity
$1,889 divided by (1.0 + (1.1224) (.05795) = $1,773.64)
Labor-related portion of adjusted cost per case, standardized for differences in teaching activity
$1773.64 × .7915 = $1403.84
Non-labor portion of adjusted cost per case, standardized for differences in teaching activity
$1773.64 − $1403.84 = $369.80
Adjusted cost per case, standardized for area wage differences
$1403.84 divided by 1.3979 (Wage index) + $369.80 = $1374.05

We did not use every case included in the MEDPAR file and from the non-MEDPAR discharge records for Maryland and Michigan hospitals in constructing the DRG weighting factors. We were concerned that those cases of a typically long or short duration would distort the results. Therefore, we eliminated all cases in each DRG for which the standardized cost values were outside three standard deviations from the geometric mean of the values for the DRG.

The average standardized cost for each of the 468 DRGs was calculated by summing the standardized adjusted costs for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. The average standardized cost for each DRG was then divided by the overall average standardized cost to determine the weighting factor.

We have depicted the construction of the DRG prospective payment weights and the case-mix indexes in the table below. The table has been structured to make DRGs 1 through 4 correspond to the 358 DRGs with sufficient Medicare cases in the 1981 MEDPAR data set. DRGs 5 and 6 correspond to the 109 DRGs with insufficient Medicare cases to which Maryland and Michigan non-MEDPAR records were added to derive the DRG weighting factors. Hospitals A through E correspond to the 5853 hospitals represented in the MEDPAR file and used to calculate the weights for the 358 DRGs with sufficient Medicare cases.

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CALCULATION OF MEDICARE PROSPECTIVE PAYMENT WEIGHTS

Standardized Cost Per Discharge, Classified By DRG[1/]

HOSPITAL	DRG 1	DRG 2	DRG 3	DRG 4	DRG 5	DRG 6	Expected Cost Per Discharge[2/]	Case Mix Index[8/]
A	1100 2000	3000	None	4000	--	--	2575	1.0210
B	None	2000 1000 5000	2000	4000 5000	--	--	3092	1.2259
C	1200 900	3000	2500 2000	3000	--	--	2367	.9384
D	2000 3000 2000	3200 2500 1900	1800 1600 1500	None	--	--	2067	.8194
E	1000	1800	1900 2300	6000	--	--	2510	.9952
Number of MEDPAR Discharges by DRG	8	9	8	5	--	--	--	--
MEDPAR Average Expected Cost Per Discharge (hospital weighted)	--	--	--	--	--	--	2522[3/]	--
DRG Cost Weight	1650	2600	1950	4400	3400[4/]	4000[4/]	--	--
MEDPAR Average DRG Cost Weight (DRG weighted)	--	--	--	--	--	--	2650[5/]	--
MEDPAR DRG Relative Cost Weights[5/]	.6226	.9811	.7358	1.6604	1.2143	1.4286	--	--
Prospective Payment DRG Relative Cost Weights[2/]	.6542	1.0309	.7732	1.7447	1.2760	1.5012	--	--

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1/ Structured to make these 6 DRGs represent all 468 DRGs. DRGs 5 and 6 correspond to the 109 low volume or empty MEDPAR DRGs for which primarily Maryland and Michigan non-MEDPAR records were used to compute the relative weights. Their weights are not derived from the national set of hospitals represented in the MEDPAR file. DRGs 1 through 4 correspond to the 358 MEDPAR DRGs with sufficient Medicare discharges.

2/ For hospital A, calculated as follows:

1/4 [2(1650) + 1(2600) + 0(1950) + 1(4400)] = 2575

3/ Computed as follows:

1/5 (2575 + 3092 + 2367 + 2067 + 2510) = 2522

4/ Based primarily on Maryland and Michigan non-MEDPAR records. MEDPAR cases were also included to the extent they were available for these DRGs.

5/ Computed as follows: 1/4 (1650 + 2600 + 1950 + 4400) = 2650

6/ For DRGs 1 through 4 (i.e. representing the 358 MEDPAR DRGs), computed by dividing each DRG cost weight by the arithmetic mean MEDPAR DRG cost weight. For DRG 1, this equals:

1650 divided by 2650 = .6226

For DRGs 5 and 6 (representing the DRGs for which primarily Maryland and Michigan non-MEDPAR discharges were used), computed by dividing each DRG cost weight by the arithmetic mean DRG cost weight for the 358 MEDPAR DRGs in the Maryland-Michigan data set. Assume, in this hypothetical example, an average of 2800, For DRG 5, this equals:

3400 divided by 2800 = 1.2143

Note that the resulting cost weights are "unweighted."

7/ For DRG 1, computed as follows:

.6226 (2650 divided by 2522) = .6542

The ratio 2650 divided by 2522 represents an adjustment factor required to properly transform the "unweighted" relative cost weights described in footnote 6. This transformation is necessary to obtain cost weights that reflect the relative cost of treatment of a case in DRG X compared to the cost of treatment of the typical Medicare discharge in the average hospital.

8/ For hospital D, computed as follows:

1/9 [3(.6542) + 3(1.0309) + 3(.7732)] = .8194

$\approx \frac{2067}{2522}$ (Numbers are not identical solely due to rounding.)

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iii. Adjustments to the Weighting Factors To Remove Kidney Acquisition Costs

Weighting factors were originally calculated including costs of kidney acquisition. To adjust the weighting factors in order to correct for treating kidney acquisition costs as a special payment under the prospective payment system, 1981 average cadaveric and live donor acquisition costs were used. These average costs were obtained from a survey of intermediaries conducted in preparation for a report to Congress on the End Stage Renal Diseases program. The average cadaveric and live donor costs were combined to obtain an overall average kidney acquisition cost. Further adjustments had to be made to this average cost since it included capital and medical education costs and it had not been standardized for area wage levels or indirect teaching costs. The adjustment for capital and direct medical education was made based on an estimate of the proportion of capital and medical education costs to inpatient operating cost. To adjust for the fact that the average costs was a hospital weighted average rather than a discharge weighted average and was not standardized, a ratio of the unweighted, unstandardized average kidney acquisition costs (after adjustment for capital and medical education) to the unstandardized, unweighted average transplant cost was calculated. The compliment of this ratio produces the portion of transplant costs unrelated to kidney acquisition and can be applied directly to the relative weight of DRG 302 to remove the value of kidney acquisition. This results in a revised weighting factor for DRG 302 of 4.2266. Once the revised weight was obtained, the weights for all DRG's were renormalized to assure the correct relative values and the case-mix index for all hospitals was recalculated. The final weight for DRG 302, after removing kidney acquisition cost and correcting the relative weights was 4.2279.

4. Calculation of Prospective Payment Rates

To ease the sudden impact of a completely new method of payment for hospital services, the statute provides for a three-year transition period. For the first three years under the prospective payment system, hospitals will be paid a prospective payment rate for each discharge that is a blend of a hospital-specific portion and a Federal portion. This section contains an explanation of how each is calculated and the formula for determining each hospital's appropriate prospective payment rate during the transition period.

a. Hospital-Specific Portion

The hospital-specific portion of the prospective payment rate is determined in a manner similar to the target amount under the rate of increase ceiling established by TEFRA. The conference committee report expresses the committee's expectation that the hospital-specific portion be based on the best data available at the time the rate is established for purposes of the transition period (H.R. Rep. No. 98–47 at p. 182). Therefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospitals entry into the prospective payment system. Once the amounts have been calculated, they will be applied throughout the entire 3-year transition period, except as indicated below.

We believe that it is important for the effectiveness of the prospective payment system to ensure that payment rates are actually prospective in their effect and as accurate as possible based on available data. To meet these objectives, the hospital may submit additional adjustment data and request an informal reconsideration of the determination within 3 weeks of receipt of the intermediary's notice of base period costs/target amount. In addition, due to the short timeframes involved in the initial implementation of the prospective payment system, we are allowing hospitals which become subject to the prospective payment system on or after October 1, 1983, and before November 16, 1983 to request that their intermediary (up to November 15, 1983) recompute their base period costs to take into account inadvertent omissions in their previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of determining base period costs. After the initial 3-week period when the hospital can submit additional adjustment data pertaining to all base year costs, omissions that can be considered under this special provision are limited to those items specified in § 405.474(b)(1)(iii)(B), for example, capital-related costs, direct medical education costs, FICA taxes, and nonphysician services billed under Part B.

We are also allowing hospitals to notify their intermediaries of errors of calculation, and we will correct such errors when notified timely, that is, within 90 days of the date on which the intermediary notifies the hospital of its rates.

Medicare fiscal intermediaries may initiate revisions to the determination of the hospital's base period costs and hospital-specific amount as follows:

- For any reason up to the date the hospital is subject to the prospective payment system;
- To make adjustments for capital-related costs and direct medical education costs and adjustments specified in paragraphs (b)(1)(iii)(A) and (b)(2)(ii) of § 405.474 during the extended reconsideration period for hospitals beginning participation in the prospective payment system on or after October 1, 1983 and before November 16, 1983; and
- To correct errors in calculation within 90 days of the date on which the intermediary notifies the hospital of its rates.

When a hospital succeeds in appealing the disallowance of costs in its base period, we will adjust the costs used in determining the hospital-specific portion for hospital cost reporting periods beginning after the date of the favorable appeal decision. We will not retroactively adjust payment rates, or adjust rates in the middle of a cost reporting period because to do so would undermine the prospectivity of the rates and would undo the budget neutrality adjustments. Therefore, we will only allow prospective adjustments to reflect revisions in base year costs when a hospital successfully contests a disallowance of costs.

If a hospital's base year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction, imposition of a civil money penalty or assessment, a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program to include costs that were unlawfully claimed, the hospital's base period costs will be adjusted to remove the effect of the excess costs, and HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. Similarly, we will adjust payments for the remaining portion of the transition period to account for the reduction in funds.

The hospital-specific portion is an amount derived from the following formula:

$$\frac{\text{(Base year costs)}}{\text{(Case-mix index)}} \times \text{Outlier adjustment} \times \text{Updating factor} \times \text{Transition period percentage} \times \text{DRG weight}$$

i. Base-Year Costs

Base year costs, necessary for calculating the hospital-specific portion of the prospective payment rates, are developed from cost data for the 12-month (or longer) reporting period ending on or after September 30, 1982 and before September 30, 1983. If the applicable period is less than 12 months, then preceding 12-month (or longer) period is used.

Costs in excess of the routine cost limits (i.e., the section 223 limits) will be excluded from base year costs in calculating the hospital-specific portion in the same manner as they are excluded when determining base period costs for the rate-of-increase ceiling under § 405.463. This is necessary for the following reasons.

- We wish to be consistent with respect to interpretation of the term "allowable operating costs" between the prospective payment system and the rate of increase ceiling.
- Inclusion of costs in excess of the limit, in determining base year costs, would result in recognition of costs which have been legitimately found to be unnecessary and unreasonable in the efficient delivery of hospital services under section 1861(v)(1)(A) of the Act.
- The method, specified in Pub. L. 98-21, of updating base period costs would carry forward those costs, recognized as unnecessary and unreasonable (inflated by the target rate percentage), into future years.
- Because of the budget neutrality provision of Pub. L. 98-21, the increased base period costs due to inclusion of costs in excess of the limits must be offset against all hospitals' costs. Therefore, inefficient hospitals would be advantaged at the expense of efficient hospitals.

Each hospital's total allowable Part A costs will be adjusted:

- To remove any capital-related costs;
- To remove any medical education costs;
- To remove the nursing differential previously permitted;
- To include allowable malpractice insurance costs;
- To include estimated FICA taxes for those hospitals that did not incur such costs for all their employees in the base period;
- To remove the kidney acquisition costs incurred by hospitals approved as renal transplantation centers; and
- To include the costs of services that were billed under Part B of the program by another provider or supplier during the base period but will be billed under Part A as inpatient hospital services effective October 1, 1983.
- To eliminate any higher costs resulting from changes in accounting principles initiated in the base period and to exclude any base year costs that were incurred for the purpose of increasing base year costs or that have the effect of distorting base year costs as an appropriate basis of the hospital-specific rate. This would involve, for example, a change in the hospital's accounting principles in pricing inventory or change from the cash to the accrual basis, or other actions taken to increase base period costs such as one-time salary bonuses and pension fund contributions. Any costs removed from the base period due to the operation of this provision would only be removed for purposes of the determination of the hospital-specific payment rates. Such costs, if otherwise allowable and reasonable in amount, would be reimbursed in the base period settlement.

In order to make some of these adjustments, the intermediary must receive documentation from the hospitals as outlined in PRM Chapter 2800 (Transmittal 291).

Total allowable Medicare inpatient operating costs for each hospital, resulting from the above adjustments, are divided by the number of Medicare discharges during the applicable base year. The amount resulting from this calculation will be used as the base year cost per case for purposes of calculating the hospital-specific portion (HSP) of the transition period prospective payment rates.

ii. Case-Mix Adjustment

In order to take into consideration the hospital's individual case mix, the base year cost amount is divided by the case-mix index applicable in FY 81 (See Table 3, section VII, of the Addendum which contains 1981 case-mix indexes.) Adjusted base period costs are divided by the hospital's case-mix index to neutralize them for the effects of the complexity of the mix of patients treated.

The effects of individual case complexity will be taken into account by multiplying the hospital-specific rate by the weighting factor for each discharge in determining the hospital-specific portion of payment for each case.

We have decided to adjust the hospital-specific rate for case-mix for the following reasons:

- It immediately protects hospitals from losses based on changes in current case mix under the prospective payment system compared to the base period, and eliminates disincentives to changes in services.
- It is conceptually consistent with the long term prospective payment approach, i.e., a specific rate for each type of discharge.
- It will facilitate the transition to the DRG prospective payment system by allowing all the planning, budgeting, and financial analysis of a hospital to be by diagnosis.
- It is responsive to concerns raised by major industry associations.

Current HCFA policy permits a hospital with a statistically unreliable case-mix index to use the higher of its published index or the average index for its classification cell under the case-mix adjusted hospital cost limits published September 30, 1982. Under those limits, the higher a provider's case-mix index, the greater its reimbursement. Under the prospective payment system transition period, the incentives are reversed. The lower the case-mix index, the greater the hospital-specific portion (HSP), since the HSP is deflated by the case-mix index. The methodology used for determining case-mix indexes is comparable to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). A case-mix index has been calculated for each hospital based on 1981 cost and billing data. At least 50 discharges are required for a hospital's case-mix index to be considered statistically reliable. For those hospitals whose case-mix index may be statistically unreliable (i.e., indicated by an asterisk in Table 3a), there is also an issue of deriving an appropriate case-mix index for the prospective payment system.

We have decided, for prospective payment purposes, when the case-mix index is statistically unreliable, to use the lower of either the published questionable case-mix index or the average index for the hospital's TEFRA cost limits classification cell, shown in Table 3b. This revises the current policy to conform with the changed incentive for a hospital to seek a lower case-mix index in view of our decision to

calculate the HSP by DRG. We believe this is a fair alternative absent sufficient data to construct a statistically reliable case-mix index. Table 3a, section VII of the addendum, contains the case-mix indexes for each hospital. The indexes based on insufficient data are indicated by an asterisk. In determining the case-mix adjustment to the hospital-specific rate for hospitals so indicated, fiscal intermediaries will use either the case-mix index from Table 3a, section VII, or the appropriate average case-mix index from Table 3b, whichever is lower. Additionally, where a hospital is not included in Table 3a (e.g., in the case of new providers), the intermediary will use the appropriate average case-mix index from Table 3b.

iii. Outlier Adjustment

The intermediary will reduce the case-mix adjusted base year costs to take into account outlier payments under § 405.475. The case-mix adjusted base year costs are multiplied by a factor calculated to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

iv. Budget Neutrality

The hospital-specific portion of the payment rates will be adjusted for cost reporting periods that begin between October 1, 1983 and October 1, 1985, to maintain budget neutrality in accordance with section 1886(e)(1)(A) of the Act. The hospital-specific portion of the rate is set at 75 percent in the first year and 50 percent in the second year.

An adjustment is made to the otherwise applicable target rate percentage to maintain budget neutrality of the hospital specific portion of the payment. To determine the necessary adjustment, we estimated expenditures for inpatient operating costs payable under the law as it was in effect on April 19, 1983, the latest date prior to enactment of the Social Security Amendments of 1983. The appropriate share of this estimate is compared to a projection of aggregate payments from the hospital-specific portion of the prospective payment amount. For example, if estimated outlays for inpatient operating payments under TEFRA would have been $10 billion, the total payments under the hospital-specific portion must equal $7.5 billion (75 percent of $10 billion) for FY 84. In making the above estimates, the statute specifies that payments made, or estimated to be made, for utilization review activities be excluded. See section VIII of the addendum which contains a detailed explanation of budget neutrality. The factor calculated to maintain budget neutrality for the FY 84 hospital-specific portion is .984. (This factor is included in the calculation of the updating factor below.)

v. Updating Factor

The case-mix adjusted base year cost is updated to apply to cost reporting periods beginning on or after October 1, 1983. To update, the base year costs are multiplied by an updating factor that is equal to be compounded applicable target rate percentage (as used for the rate of increase ceiling under revised § 405.463), multiplied by the adjustment factor for budget neutrality and added to 1.0.

The target rate percentages are based on the latest available calendar year market basket inflation rates plus one percentage point. Based on the most recent market basket data, the target rate percentages for calendar years 1982 through 1984 are as follows:

Calendar year	Target rate percentages (percent)
1982	10.3
1983 [1]	7.2
1984 [1]	6.8

[1] These rates will be updated regularly using the latest available data. The updated target rate percentages and the resulting budget neutrality adjusted updating factors will be published in a quarterly FEDERAL REGISTER notice.

In order to compute an updating factor, the above target rate percentages are compounded using the number of months in each calendar year and applying the adjustment factor for budget neutrality (.984 for FY 84). The chart below shows the updating factor for each base year month.

COMPOUNDED PROSPECTIVE PAYMENT, TARGET RATES OF INCREASE ADJUSTED FOR BUDGET NEUTRALITY FOR HOSPITAL-SPECIFIC PORTION (10/1/83 CYCLE)

If 12-month base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658 **
Jan. 31, 1983	Jan. 31, 1985	1.12658 **
Feb. 28, 1983	Feb. 28, 1985	1.12658 **
Mar. 31, 1983	Mar. 31, 1985	1.12658 **
Apr. 30, 1983	Apr. 30, 1985	1.12658 **
May 31, 1983	May 31, 1985	1.12658 **
June 30, 1983	June 30, 1985	1.12658 **
July 31, 1983	July 31, 1985	1.12658 **
Aug. 31, 1983	Aug. 31, 1985	1.12658 **

** These updating factors are subject to change depending on changes in the target rate percentages used to compute them. We will publish a quarterly notice in the FEDERAL REGISTER setting forth the percentages and factors to be used for cost reporting periods beginning in the subsequent calendar quarter.

If a hospital's base year cost reporting period ends on a day other than those listed above, the intermediary will use the nearest whole month to the date on which the hospital's cost reporting period actually ends. For example, if a hospital's base year cost reporting period ends on December 27, 1982, the inflation factor for cost reporting periods ending December 31, 1982 will be used.

If a hospital's base year cost reporting period is other than as specified above, the intermediary should contact HCFA for the appropriate updating factor.

In subsequent years, the hospital specific rate will be increased by multiplying the previous year's hospital-specific rate by the updating factor. This factor will be published annually in the **Federal Register.**

vi. Example of Calculation of Hospital Specific Rate

Assume that a hospital's base year costs equal $3,000, its case-mix index is 1.0235, the outlier adjustment is .943 (i.e., 1.0 − 0.057), and the prorated updating factor for its cost reporting period is 1.14258. The hospital specific rate would be computed as follows:

Base year costs / Case-mix index	×	Outlier adjustment	×	Updating factor	=	Hospital specific rate
3000 / 1.0235		.943		1.14258		$3,171.54

vii. Calculation of Hospital-Specific Portion

The hospital-specific portion of a hospital's transition payment rate for a given discharge is calculated by:

Step 1—Multiplying the hospital-specific rate by the appropriate percent (as explained in section 4.c. below). (Following the end of the 3-year transition period, the hospital-specific portion will no longer be determined for hospitals participating under the prospective payment system, except for sole community hospitals, which will continue to be paid a rate based on the first-year transition rates.)

Step 2—Multiplying the amount from Step 1 by the specific DRG weighting factor applicable to the discharge (see Table 5, section VII of the addendum).

viii. New Providers

A relatively small number of hospitals are likely to begin operation during the transition period. For these new providers there is no historical cost experience on which to base a target amount. The report of the Committee on Ways and Means, in considering H.R. 1900 H.R. Rep. No. 98–25, 98th Cong. 1st Sess, 137 (1983), expresses

Congressional intent that such hospitals be included under the prospective payment system. The Committee expects the Secretary to make "appropriate provision" for applying a prospective payment rate. Although the Committee report suggests that this might be accomplished by applying the average hospital operating cost limit for the classification group applicable to the new provider's location and bed size, we believe an alternative method of paying new providers is more appropriate in view of the other adjustments necessary in computing the hospital-specific rate, and because we have no historical data or experience that would justify such a policy.

For new providers, we will not apply the hospital-specific portion of the prospective payment rate. Instead, full payment to these providers will be based on a blend of regional and national Federal rates only. That is, rather than following the phase-in period as described in section III. C.4.c. of this preamble (i.e., blending a hospital-specific rate with a Federal rate), new providers will use a phase-in methodology combining regional and national Federal rates only, as described in section III. C.4.d. of this preamble.

b. Federal Portion

The Federal portion of the prospective rate, during the transition period, is a percentage of the Federal prospective rate. The applicable percentages for each year are presented in section c. below. During the first year of the transition period, the Federal rate will be derived from the regional urban and rural standardized amounts. During the second and third year of the transition period, the Federal rate will be comprised in part from regional urban and rural standardized amounts and in part from national urban and rural standardized amounts.

The Federal rates are determined by:

Step 1—Selecting the appropriate regional or national adjusted standardized amount considering the location and urban/rural designation of the hospital (see Table 1, section VII of the addendum);

Step 2—Multiplying the labor-related portion of the standardized amount by the appropriate wage index;

Step 3—For hospitals in Alaska and Hawaii, multiplying the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor;

Step 4—Summing the amounts from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3); and

Step 5—Multiplying the final amount from step 4 by the weighting factor corresponding to the appropriate DRG classification.

c. Phase-In Period

The total prospective payment rate containing the hospital-specific portion and the Federal portion for discharges in a given cost reporting period are calculated as described below.

i. For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the prospective payment rate is equal to the sum of:

(A) 75 percent of the hospital-specific rate, plus

(B) 25 percent of the appropriate Federal prospective rate. The Federal rate will be 100 percent of the regional rate for discharges occurring before October 1, 1984. After that date the Federal rate will be 75 percent of the regional rate and 25 percent of the national rate.

ii. For cost reporting period beginning on or after October 1, 1984 and before October 1, 1985, the prospective payment rate is equal to the sum of:

(A) 50 percent of the hospital-specific rate, plus

(B) 50 percent of the Federal prospective rate. The Federal rate will be 75 percent of the regional rate and 25 percent of the national rate for discharges occurring before October 1, 1985. After that date the Federal rate will be 50 percent of the regional rate and 50 percent of the national rate.

iii. For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the prospective payment rate is equal to the sum of:

(A) 25 percent of the hospital-specific rate, plus

(B) 75 percent of the Federal prospective rate. The Federal rate will be 50 percent of the regional rate and 50 percent of the national rate for discharges occurring before October 1, 1986. After that date the Federal rate will be 100 percent of the national rate.

iv. For cost reporting periods beginning on or after October 1, 1986, all hospitals (including hospitals that begin operation on or after that date) paid under the prospective payment system will be paid at the national Federal prospective payment rates, except for those hospitals eligible for special treatment as provided in § 405.476.

d. Phase-In Period for New Providers

As was stated in section III.C.4.a.viii. above, new providers will be paid prospective payment rates based entirely on the Federal rates. Therefore, in determining prospective payment rates for new providers, we will blend the regional and national Federal rates as follows:

i. For discharges occurring on or after October 1, 1983 and before October 1, 1984, the prospective payment rate is equal to the regional Federal prospective rate.

ii. For discharges occurring on or after October 1, 1984 and before October 1, 1985, the prospective payment rate is equal to the sum of:

(A) 75 percent of the regional Federal prospective rate, plus

(B) 25 percent of the national Federal prospective rate.

iii. For discharges occurring on or after October 1, 1985 and before October 1, 1986, the prospective payment rate is equal to the sum of:

(A) 50 percent of the regional Federal prospective rate, plus

(B) 50 percent of the national Federal prospective rate.

iv. For discharges occurring on or after October 1, 1986, the prospective payment rate will equal the national Federal prospective payment rates.

e. Annual Update of Schedule of Standardized Amounts

i. Update of Standardized Amounts for FY 85

For FY 85, the average standardized amount determined for FY 84 will be increased by the estimated applicable percentage change in the cost (excluding non-operating costs) of the mix of goods and services comprising routine, ancillary, and special care unit inpatient hospital services for FY 85 over those in FY 84 (i.e., market basket), plus 1 percentage point. HCFA will use the market basket index that appropriately weights indicators of changes in wages and prices that are representative of the mix of goods and services included in inpatient hospital operating services. Additionally, the updated standardized amounts for FY 85 will be adjusted for "outliers", for unbundling, and for adjustments that may be necessary to maintain budget neutrality. We will publish a notice in the **Federal Register** by September 1, 1984 announcing the updated standardized amounts.

ii. Update of Standardized Amounts Beginning—FY 86

For years beginning with FY 86 (i.e., applicable for cost reporting periods beginning on or after October 1, 1985), the Secretary will determine the update factor which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

In determining the update factor, the Secretary will take into account such factors as changes in the market basket, productivity, technological and scientific advances, quality of health care, the long-term cost-effectiveness of the program, and recommendations of a commission of independent experts, the Prospective Payment Assessment Commission. This commission will be appointed by the Director of the Congressional Office of Technology Assessment to review the adequacy of the payment rates and to make recommendations to the Secretary.

The Secretary's proposed update factor and the recommendations of the commission will be published in the **Federal Register** for public comment by June 1 each year. The final percentage increase will be published by September 1 each year.

HCFA will adjust the DRG classification and weighting factors for FY 86 and at least once every four years thereafter to reflect changes in treatment patterns, technology, and other factors that may alter the consumption of hospital resources. Adjustments may be made to individual DRG classifications and would not necessarily involve rebasing the entire classification system. The Commission shall consult with and make recommendations to the Secretary with respect to the need for adjustments.

D. Additional Payment Amounts

In addition to prospective payment rates per discharge, payments will be made for items or services as specified below.

1. Outliers

Section 1886(d)(5)(A) of the Act requires that additional amounts be paid for atypical cases known as "outliners". These cases are those that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

The regulations on outlier payments are at § 405.475. These regulations provide that a discharge will qualify as an outlier if the length of stay exceeds the average length of stay for discharges in the DRG by a fixed number of days or a fixed number of standard deviations, whichever is the fewer number of days. A per diem payment will be made for each covered day of care beyond the outlier threshold. Upon the request of a hospital, an extraordinarily high cost case, that does not qualify as an outlier based on length of stay, will qualify for an outlier payment if covered charges, adjusted to operating cost, exceed a fixed multiple of the Federal prospective payment rate or a fixed dollar amount whichever is greater. (See III.J.1.d.ii.C. of this preamble for a discussion of medical review of outlier claims).

Since total outlier payments must be between 5 and 6 percent of the total prospective payments estimated for the fiscal year, the specific criteria for determining whether a case qualifies for an outlier payment may change each fiscal year and will be published as part of the annual notice setting forth the standardized amounts and factors necessary to determine prospective payment rates. The FY 84 threshold criteria are published in the addendum to the regulations. These criteria should result in outlier payments approximating 6.0 percent of the estimated FY 84 total prospective payments (including outlier payments). As explained elsewhere in this preamble, we have adjusted the amount of basic prospective payment rates to achieve this result (section III.C.1.e.iii and III.C.4.a.iii).

We are providing that a discharge in FY 84 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within that DRG by the lesser of 20 days or 1.94 standard deviations. The first criterion will primarily identify cases in the long-stay, resource intensive DRGs, whereas the second criterion should identify slightly less than 2 percent of the cases within primarily short-stay DRGs as outliers. In total, we estimate 5.1 percent of all cases will qualify as day outliers.

We established the day outlier criteria based on the geometric mean length of stay for each DRG. We used the geometric mean (the antilogarithm of the mean of the logarithms of length of stay) instead of the arithmetic mean because the length of stay data are highly skewed. That is, there are cases at the high end of the distribution which are not matched at the low end. This occurs because, while there is no limit to how long an inpatient stay can be, the number of days can never be below zero. By using the geometric mean, the percent of cases that will be outliers within each DRG is more predictable. Overall, the geometric criteria will identify a smaller percentage of total discharges as outliers. However, because the geometric mean is lower than the arithmetic mean, the per diem payment rate under the geometric criteria is higher.

For FY 84, we are also providing that a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 1.5 times the Federal rate (regional) for the DRG or $12,000. Both criteria will be adjusted for area wage differences. The first criterion will operate only for the relatively few DRGs with a Federal rate of $8,000 or more. In most cases, the $12,000 criterion will operate. In total, we estimate .9 percent of all cases will qualify as high cost outliers.

We selected criteria that will result in substantially more cases being identified as day outliers than as cost outliers for two basic reasons. First, the identification and payment determination for day outliers will be an automatic feature of the intermediary bill processing system. Hospitals must identify and specifically request payment for cost outliers and the intermediary must review and make a payment determination in each case. Thus, cost outliers carry a greater administrative burden for both hospitals and HCFA. Second, because the application of the outlier criteria is sequential (a discharge cannot be considered a cost outlier if it meets the applicable day outlier criterion), the day outlier criteria would have to be set very high and the cost criteria would have to be set very low in order to obtain an even allocation of payments between types of outliers. A low threshold for cost outliers could result in outlier payments simply because the hospital is a high cost provider, and not as a direct consequence of extraordinary services provided an individual patient.

The statute specifies that the outlier payments should approximate the marginal cost of care beyond the cut-off criteria. Marginal cost is the change in total cost associated with a one unit change in output. Due to the presence of fixed costs, the marginal cost of care is generally less than the average cost. In the short run, marginal cost is usually low since hospitals cannot respond to volume changes by immediately adjusting costs such as labor. Depending on the measure of output (days, admissions or services) and the time interval examined, estimates of marginal cost have ranged from 21 percent to over 90 percent of average cost. The analyses suggest that the short-run marginal cost to average cost ratio is less than .58 and with patient days as the measure of output, as low as .22. (J. Lipscomb, I. Raskin, and J. Eichenholz, "The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy," *Hospital Cost Containment: Selected Notes for Future Policy*, ed. M. Zubkoff, I. Raskin, and R. Hanft (New York: Prodist, 1978), pp. 527–532.)

To date, the estimates of the ratio of marginal cost to average cost have been based on total costs, including capital-related and medical education costs. We

believe an estimate of marginal cost to average operating costs would be somewhat higher.

Therefore, the regulations provide that the marginal cost of outlier care will be based on a 60 percent factor.

For day outliers, an additional per diem payment will be made for each covered day of care beyond the threshold (including SNF-level days of care when a SNF bed is not available). The per diem payment will be based on 60 percent of the average per diem Federal rate for the DRG. The average per diem payment is determined by dividing the wage-adjusted Federal rate for the DRG by the mean length of stay for that DRG. For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1984, the Federal rate will be 100 percent of the regional prospective payment rate. During the remainder of the transition period, it will be a combination of the Federal national and regional prospective payment rates.

For high cost outliers, the regulations provide that the additional payment will be based on 60 percent of the difference between the hospital's adjusted cost for the discharge and the threshold. The cost of the discharge will be determined by multiplying the billed charges for covered services by .72. This figure represents a national ratio of Medicare inpatient operating costs to Medicare inpatient charges and was derived from an analysis of the cost and billing data used to establish the DRG relative weights. We are removing the non-operating costs since payment for these costs will be made on a reasonable cost basis. The cost will be further adjusted to exclude an estimate of indirect medical education costs. This adjustment is necessary since payment for indirect teaching costs is separately determined based on total federal DRG revenue. If these costs were not removed, we would be paying for them twice. For those few hospitals who receive a Section 602(K) waiver (see Part V of this preamble), the cost will also be adjusted to include the reasonable charges for non-physician services billed by the outside supplier.

The following is an example of how the additional payment will be determined for a high cost outlier:

Step 1—Determination of the Hospital's Cost:

Billed Charges = $35,000	
National Ratio of Cost to Charges	.72
Educational Adjustment Factor	1.1924

$$\text{Hospital's cost} = \frac{\$35{,}000 \times .72}{1.1924} = \$21{,}134$$

Step 2—Determination of Outlier Threshold:

Federal DRG Rate = $3800	
Wage Index	1.10
Labor-Related Portion	.7915
Non-Labor Related Portion	.2085

Since 1.5 times the DRG rate would be less than $12,000, the threshold will be based on $12,000

Wage-Adjusted Threshold = ($12,000 × .7915 × 1.10) + (12,000 × .2085) = $12,949.

Step 3—Determination of Outlier Payment: Outlier Payment = ($21,134 − $12,949) × 60% = $4,911.*

*This payment will be included in total Federal DRG revenue for puposes of the educational adjustment.

The relationship between the educational adjustment factor and outlier payments is as follows:

- The additional payment for indirect medical education costs is intended to account for a variety of factors which may legitimately increase costs in teaching institutions. Since many of these factors are as applicable to the outlier portion of an inpatient stay as they are applicable to the non-outlier portion, an additional payment will be made for the indirect medical education costs associated with the marginal cost of outlier care.
- The additional payment for indirect medical education costs associated with length of stay outliers will be determined by applying the educational adjustment factor to the outlier payment. In the case of a high cost outlier, the hospital's costs include indirect teaching costs that must be removed before determining the amount of the outlier payment. Once the outlier payment has been determined, the additional payment will be made for the associated indirect medical education costs by applying the educational adjustment factor to the outlier payment.

2. Alternate Placement Days

Medicare provides for continued coverage when a beneficiary who no longer requires an acute level of hospital care remains hospitalized because medically necessary skilled nursing facility (SNF) services are not available. Until the 1980 and 1981 Reconciliation Acts, reimbursement for these alternate placement days was at the regular hospital rate. In order to reduce program expenditures and encourage the conversion of excess hospital beds into long-term care beds, Congress passed section 1861(v)(1)(G) of the Social Security Act which provides that alternate placement days must be reimbursed at the estimated Medicaid SNF rate if there are excess hospital beds in the facility or in the area. If there are no excess hospital beds, reimbursement is at the regular acute care hospital rate.

The reimbursement provisions of section 1861(v)(1)(G) have not been implemented. As a result, the SNF-level alternate placement days have not been distinguished from other inpatient hospital days and are included at full cost in the data bases used to establish the prospective payment rate. Given the presence of the alternate placement days in the data base and in view of the incentive hospitals will have under the prospective payment system to reduce the incidence of alternate placement days by locating available SNF beds in the area or converting excess capacity to SNF beds, we are continuing to treat alternate placement days the same as other inpatient hospital days. No separate payment will be made for the alternate placement days occurring in a regular inpatient stay. However, medically necessary SNF-level days of care will continue to constitute covered inpatient hospital services and will qualify for an outlier payment when the outlier threshold is crossed.

3. Additional Payments on Reasonable Cost Basis

a. Capital-Related Costs

In accordance with the statute, payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. During the transition period, the capital-related costs must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate.

b. Direct Medical Education

In accordance with the statute, the direct costs of medical education programs will be reimbursed on the basis of reasonable cost subject to applicable regulations in Subpart D.

c. Direct Medical and Surgical Services of Teaching Physicians

Payment for direct medical and surgical services of physicians in teaching hospitals will be made on a reasonable cost basis under § 405.465 where the hospital exercises the election as provided for in § 405.521(d).

4. Bad Debts

An additional payment will be made to each hospital in accordance with

§ 405.420 for bad debts attributable to deductibles and coinsurance amounts related to covered services received by beneficiaries.

5. Indirect Medical Education

Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method.

If a hospital has a graduate medical education program approved under 42 CFR 405.421, an additional payment will be made equal to 11.59 percent of the aggregate payments made to the hospital, based on the Federal portion of prospective payments and outlier payments related to those portions, for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents (in approved programs) to its bed size. The number of full-time equivalent interns and residents is the sum of:

1. Interns and residents employed for 35 hours or more per week, and

2. One half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

For purposes of this adjustment, a hospital will be allowed to count only interns and residents in teaching programs approved under 42 CFR 405.421 who are employed at the hospital. Interns and residents in unapproved programs and those who are on the hospital's payroll but furnish services at another site will not be taken into account in making this adjustment nor will interns and residents employed to replace anesthetists. In determining the amount of the adjustment, the fiscal intermediary will use the number of interns and residents employed at the end of the immediately preceding cost reporting period.

The teaching adjustment does not apply to any hospital not paid under the prospective payment system, such as those hospitals or distinct part psychiatric and rehabilitation units that are paid on a reasonable cost basis, since the payments to those facilities already include the indirect costs of medical education. Therefore, the number of beds in an excluded psychiatric and rehabilitation unit, as well as interns and residents assigned those units, may not be included in calculating the ratio of interns and residents to beds. However, due to the way in which the adjustment factor was originally computed, interns and residents working in outpatient areas and emergency rooms should be included in the calculation of the ratio. In the original computation of the adjustment factor, interns and residents working in these areas were included in the analysis, even though the costs were excluded. Further, these areas would not affect the bed count assigned to the facility. Therefore, if we were to exclude these interns and residents in applying the factor, the amount of the adjustment would be incorrect because we would be altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factor and subsequently standardizing hospital costs based on that factor.

Congress was particularly concerned that the prospective payment system not have an adverse impact on teaching hospitals because these hospitals provide an essential service in that they assure a continuing supply of essential health care personnel. As a result, the statute requires that the teaching adjustment factor under the prospective payment system be computed in a manner similar to the adjustment in effect on January 1, 1983, except the adjustment factor shall equal twice the factor determined under that method.

In computing the education adjustment for the prospective payment system, we calculated the adjustment factor from 1981 base year cost data using the same methodology used to calculate the indirect medical adjustment figure from 1980 cost data for the cost limits in effect on January 1, 1983. We used this method, rather than simply multiplying the previous adjustment factor by 2, because we wanted to relate the payment rate and the adjustments to the same data base, 1981 cost data, before doubling the adjustment factor.

The teaching adjustment factor is computed by comparing the inpatient operating costs of all hospitals. Using the ratio of FTE interns and residents to beds as a variable to measure relative intensity of teaching activity, we estimated the effect of teaching activity on operating costs through regression analysis in the same manner as used previously. Since the 1980 data base used to calculate the teaching adjustment factor in effect on January 1, 1983, did not include malpractice insurance as an operating cost, while the prospective payment system includes malpractice insurance as an operating cost, it is inappropriate to update the data before doubling the adjustment factor. Additionally we have a new series of case-mix indexes and wage indexes (i.e., based on 1981 data) to be included. Therefore, we have recomputed the adjustment factor using the same data used to calculate the standardized amounts and doubled that result.

The resulting teaching adjustment factor is 11.59 percent. The adjustment factor is applied only to revenue under the Federal portion of the payment rates. Since the hospital-specific portion of the rates is based on the hospital's actual allowable costs, this portion already includes the higher costs of indirect education in an individual hospital. Therefore, it would not be appropriate to increase this portion of the prospective payment rates further.

An example of the application of indirect teaching adjustment payment follows:

A 686-bed hospital in Queens County, New York has a total revenue from the Federal portion of the prospective payments of $1.32 million. The hospital employed 77 FTE interns and residents in approved teaching programs on September 30, 1983 (their cost reporting period ending date).

77 divided by 686 = .11224 (ratio of interns and residents to beds) divided by .1 = 1.1224 (adjusted ratio).

Federal portion of DRG revenue × teaching adjustment factor × adjusted ratio = additional payment amount
$1,320,000 × .1176 × 1.1224 = $174,232.

The indirect teaching adjustment payment is an annual lump sum additional payment to teaching hospitals. However, to alleviate cash flow problems for these hospitals, the intermediary may include estimated teaching adjustment amounts in the periodic payment to the hospital. If a hospital does not have a graduate medical education program approved under 42 CFR 405.421, the education adjustment will not apply.

E. Interim Payments

1. General

The prospective payments for inpatient hospital operating costs (a blend of hospital-specific and Federal payment rates during a 3-year transition period), including amounts for outlier cases, are intended to represent final payment for services rendered. Excluded from inpatient operating costs are capital-related costs and direct medical education costs. (See § 405.2102(e)(1) regarding kidney acquisition costs in hospitals approved as renal transplantation centers.) These costs and the costs of services rendered to inpatients under Part B when Part A benefits are not payable and outpatient

services continue to be reimbursed on a reasonable cost basis. In addition, payments to hospitals and distinct part hospital units which are exempt from the prospective payment system continue to be made on a reasonable cost basis.

Prior to implementation of the prospective payment system, hospitals may receive interim payments for their costs of covered inpatient and outpatient services furnished to Medicare beneficiaries as described in 42 CFR 405.454(a) through (j). Those interim payments are computed to approximate as closely as possible actual reimbursement which will be determined at year end based on the hospital's submitted cost report. There are two methods of interim reimbursement for inpatient hospital services.

One method is based on actual bills submitted by the hospital. Under this method, interim payments are calculated by applying a predetermined per diem amount to the number of days reflected on actual bills or by applying a predetermined percentage to the charges reflected on the actual bills submitted. The predetermined per diem amount or percentage factor applied to billed patient days or charges represents an estimate of the hospital's costs as related to days or charges which will be incurred.

Under the second method, referred to as the periodic interim payment (PIP) method, interim payments are not made based on individual bills. Instead, total reimbursable cost for the year is estimated and periodic level payments are made to hospitals without regard to the submission of individual bills. Under either interim reimbursement method, any over or under estimation of the hospital's actual costs, to the extent not adjusted during the year, is adjusted at the time of cost report settlement.

Effective with cost reporting periods beginning on or after October 1, 1983, hospitals subject to the prospective payment system for Part A inpatient services will be paid a prospectively determined amount for each discharge based on actual bills submitted. Such payment constitutes final payment for each discharge claimed. On the other hand, hospitals meeting the qualifications for PIP in § 405.454(j) may elect to receive level biweekly payments representing their estimated annual prospective amounts. Only in this circumstance would year-end reconciliation be required.

Payments for costs of capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers, which are payable on a reasonable cost basis, continue to require interim payments and a year-end reconciliation based on a submitted cost report. In addition, the indirect teaching adjustment, if appropriate, will be paid on an interim basis subject to final settlement.

Interim payment for all services under the prospective payment system are specifically addressed in a new § 405.454(m). Cost of services rendered to inpatients under Part B when Part A benefits are not payable and rendered to outpatients continue to be reimbursed as currently addressed in § 405.454.

2. Methodology for Determining Payments Under PPS

Except for hospitals qualifying to receive payments under the PIP method, prospective payments for Part A inpatient operating costs will be made on the basis of a submitted bill. Such payments represent final payments and are not subject to retroactive adjustment at the end of the hospital's fiscal year. Payment for outlier cases may be computed and paid only after the intermediary is assured that the outlier claim is justified. Payment for outliers resulting from extraordinary costs, i.e., cost outliers, must be requested by the hospital and are payable after approval, subject to a medical review determination. Payment for day outliers, i.e., outliers resulting from length of stay exceeding the day outlier threshold criteria for the DRG, need not be specifically requested by the hospital and can be paid after a medical necessity determination is made, along with the prospective payment for the discharge.

We recognize that errors can be made, and adjustment bills to correct errors will be submitted after the initial bill is submitted. Such adjustment bills will be scrutinized closely to ensure correctness and completeness. Copies of medical records or other evidence may be requested to document procedures, diagnoses, etc.

Hospitals (including hospitals not previously on PIP) that meet the qualifications in § 405.454(j) may elect to receive their prospective payments in the form of level payments. They may convert to payments on a per discharge basis at any time. For hospitals making the election to receive level payments, the interim payment amount will be based on the total estimated discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. This amount is the blended sum of the hospital-specific rate and the Federal rate multiplied by the hospital's case-mix index. The total estimated annual amount will be paid in 26 equal biweekly payments. The payments will be reviewed and adjusted at least twice during the reporting period and are subject to final settlement at year end. For hospitals making this election, payment for outliers will not be included in the biweekly payments. Rather, the payments for both day and cost outliers, after medical review approval, will be paid based on submitted bills. These additional payments will be final with no retroactive year end adjustment.

During the early period that a hospital first becomes subject to the prospective payment system, some patients discharged will have been admitted in the prior period. Prospective payments must be adjusted for the portion of the stay occurring in the prior period which was reimbursed on a reasonable cost basis. The adjustment will be made by subtracting from the prospective payment rate (made either on the basis of a bill or on level payments) the hospital's interim reimbursement for inpatient operating costs applicable to the days in the prior period. The interim reimbursement applicable to the prior period must be adjusted to exclude costs related to capital and direct medical education.

Accelerated payments will be available only to hospitals not electing to receive level payments and which demonstrate the existence of cash flow problems caused by a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle.

For items applicable to inpatient hospital services not reimbursable on a prospective basis (capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers, and the indirect teaching adjustment), interim payments will be made subject to final settlement. Interim payments for capital-related and direct medical education costs and for kidney acquisition costs in hospitals approved as renal transplantation centers will be determined by estimating the reimbursable amount for these costs for the year, using Medicare principles of cost reimbursement, and dividing it into 26 equal biweekly payments. If appropriate, these payments will be combined with the biweekly interim payments for inpatient services subject to the prospective payment system. The estimated amount may be based on the previous year's experience and on additional substantiated information for the current year. The interim payments will be reviewed and adjusted at least

twice annually by the intermediary with final settlement based on a submitted cost report.

Level payments on a biweekly basis for capital-related and direct medical education costs are required and are not at the hospital's option. Interim payment on the basis of a percentage of billed charges or on an average cost per diem will no longer be available to hospitals subject to prospective payment for Part A inpatient services.

The indirect teaching adjustment is calculated based on the Federal portion of the prospective payment amount. To estimate the adjustment, the hospital's total discharges for the reporting period and the ratio of full time equivalent (FTE) interns and residents to the number of hospital beds must be estimated and multiplied by the education adjustment factor. The total estimated annual amount of the adjustment will be divided into 26 biweekly payments and combined with inpatient costs reimbursed on a reasonable cost basis. This estimate is subject to year end adjustment.

To reflect these changes, § 405.454(a) has been revised and a new paragraph (m) has been added to § 405.454, "Payments to providers".

F. Change of Ownership

The circumstances under which a change of ownership is recognized are described in 42 CFR 489.18. Under prior law, which reimbursed reasonable costs and required that providers file cost reports, the last cost reporting period ended and a new one began on the date a provider changed ownership. Costs were accumulated, reported, and reimbursed accordingly. Under the new law, Medicare prospective payments for inpatient operating costs are to be made on a discharge basis, so that the correct amount of the payment cannot be known until the beneficiary is discharged from a hospital. Further, the payment represents full payment for the entire patient stay.

In accordance with regulations at § 405.477(f), payment for inpatient operating costs, including outlier payments and payments for indirect teaching costs, will be made to the legal owner or operator of the hospital as of the date of discharge, without proration between the buyer and seller. It is the intent of the Medicare program that any adjustments to any prospective payments be negotiated by the former and new owners as they see fit, without Government involvement or interference. The capital-related costs and the direct costs of approved medical education programs will continue to be reimbursed on a reasonable cost basis. As such, each party to the sale will be reimbursed for these costs in accordance with the costs incurred and the return on equity capital in the case of for-profit hospitals during each party's respective period of participation.

There is no change to our rules and policies with respect to revaluation of assets, treatment of goodwill, etc., upon the sale, transfer or other change of ownership. The direct capital-related costs and costs of approved medical education programs will continue to be paid on the basis of reasonable costs, and there will continue to be a need to accumulate costs and charges separately for the pre- and post-change of ownership so that those costs can be properly allocated.

G. Special Treatment of Sole Community Hospitals, Christian Science Sanitoria, Cancer Hospitals, Referral Centers, and Certain Kidney Acquisition Costs Incurred by Renal Transplantation Centers

Section 1886(d)(5)(C) of the Act authorizes the Secretary to make certain exceptions and adjustments to the prospective payment rates under circumstances as he or she deems appropriate. The Secretary is authorized to make adjustments for:

- Regional and national referral centers,
- Hospitals with disproportionate numbers of low income and/or Medicare beneficiaries,
- Sole community hospitals,
- Hospitals extensively involved in treatment for and research on cancer,
- Hospitals in Alaska and Hawaii (addressed in section III.C. of this preamble), and
- Other exceptions and adjustments as the Secretary deems appropriate.

1. Sole Community Hospitals (SCHs)

Section 1886(d)(5)(C)(ii) of the Act requires the Secretary to take into account the special needs of SCHs by using a special payment formula for hospitals so classified. The law defines SCHs as those that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), are the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under Part A of the program. Regulations regarding SCH exceptions are set forth at § 405.476.

a. Criteria for SCH Status

A hospital will be classified as an SCH for purposes of the prospective payment system and receive payment adjustments if the hospital has an approved exemption from hospital cost limits (see § 405.460) as an SCH prior to October 1, 1983. However, if there is a change in circumstances affecting this classification under the cost limits, the classification for purposes of adjustments under prospective payment will be reevaluated in accordance with other criteria explained below.

Hospitals which have not been approved for an exemption prior to the effective date of these regulations must be located in a rural area and meet one of the following criteria in order to be classified as a SCH.

i. The hospital is located more than 50 miles from other like hospitals; or

ii. The hospital is located between 25 and 50 miles from other like hospitals and either:

- No more than 25 percent of the residents in the hospital's service area are admitted to other like hospitals for care, or
- Because of local topography, weather, etc., the other hospitals are generally not accessible for more than one month during a 12-month period; or

iii. The hospital is located between 15 and 25 miles of other like hospitals and because of local topography, weather, etc., the other hospitals are generally not accessible for more than one month during a 12-month period.

We recognize that it might be to a hospital's advantage in certain instances to give up its SCH classification and elect to be reimbursed under the prospective payment system as other hospitals in the region. Although Congress did make special provisions for SCHs, we do not believe it was the Congressional intent to permit hospitals to continually alter the method under which they are reimbursed solely to maximize reimbursement. Therefore, we are permitting hospitals to voluntarily give up their SCH classification at any time.

However, this decision is irrevocable unless all other hospitals within 50 miles close.

A SCH classification is not available for those hospitals located within 15 miles of another hospital nor for those located in an urban area unless they qualify under paragraph i. above. Since EOMB considers local commuting patterns in establishing urban designations, we presume that residents in urban areas have access to hospital services either by living in close proximity to a hospital or by establishing a heavy commuting pattern to an area in which a hospital is located

For purposes of evaluating whether a hospital meets the criteria for aSCH classification, HCFA will measure the distance between hospitals using "improved road miles." We have decided to use improved road miles rather than radius miles because this is the actual distance that must be traveled in order to reach alternative hospital services. An improved road is a road which is maintained for regular use by a governmental entity (i.e., local, State, or Federal) and which is available for use by the general public.

HCFA will consider "like" hospitals as those hospitals furnishing short-term acute care. A hospital may not qualify for a SCH classification on the grounds that neighboring hospitals do not offer comparable specialty services. Thus, a hospital that has an intensive care unit but is located only 12 miles from another acute care hospital without such specialty services would not be granted a SCH classification.

For the purpose of evaluating utilization outside of the service area, the service area would be defined as the geographical area from which the hospital draws or expects to draw its patients. Optimally, the boundaries of the service area would be defined by a statewide planning agency. If not, the hospital would determine the service area based on where it draws at least 75 percent of its admissions. A hospital must submit admissions data documenting the boundaries of its service area if such boundaries are not established by a statewide planning agency. In order to document that no more than 25 percent of the residents of the service area utilize services outside of the area, hospitals must also gather and submit applicable admissions data from all surrounding hospitals located within 50 miles of the requesting hospital.

Finally, those hospitals requesting an SCH classification on the grounds that alternative hospitals were inaccessible for more than one month each year must submit data to document a history of such inaccessibility. For example, reports of a State Highway Department or local public safety officials specifying the locations of road closure and periods of time the road was inaccessible over the past three years would be necessary to substantiate the request. The fact that alternative hospital services were not available during one month of a single 12-month period is not sufficient evidence to substantiate the prolonged and predictable inaccessibility intended in this criterion.

b. Procedures for SCH Classification

Hospitals may submit a written request to be designated as an SCH to the appropriate intermediary at any time during their cost reporting period. The intermediary, based on the information submitted, will send its recommendation regarding the request to HCFA. HCFA will make the final determination and will respond in writing to the intermediary. The hospital will receive notification of the decision from its intermediary. The new payment rates for an SCH as described in c. below, will be effective 30 days after the date of HCFA approval. There will be no retroactive effective dates on SCH designations.

Once a hospital is classified as an SCH, at its option it retains that classification indefinitely until there is a change in circumstances suggesting a need for reevaluation (for example, if there is a change in MSA designations).

c. Payment to SCHs

Hospitals, that are classifed as SCHs, will be paid in accordance with the methods of establishing rates for the first year of the transition period (i.e., effective with the first cost reporting period on or after October 1, 1983). Use of the methods for rates established for the first year of the transition period (i.e., 75 percent of the hospital-specific rate and 25 percent of the Federal rate) will continue to be the basis of payment to SCHs indefinitely.

In addition to the payment rates calculated as explained above, SCHs may also receive an additional amount if the hospital has experienced a decrease of more than five percent in its total number of inpatient cases, due to circumstances beyond its control. However, this additional payment only applies during the transition period.

i. Criteria for Determining Eligibility for Additional Payments

Effective for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, if an SCH experiences more than a 5 percent decrease in its total number of inpatient cases, i.e., discharges, compared to the immediately preceding cost reporting period, HCFA will provide for a payment adjustment.

The basic test for evaluating a hospital's request for special payment due to extraordinary circumstances is that the decrease in volume is the result of an unusual situation or occurrence externally imposed on the hospital and beyond its control. Such situations may include, but are not limited to, strikes, fires, earthquakes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, or similar unusual occurrences with substantial cost effects.

In making the comparision of dicharges, the number of discharges in a cost reporting period is compared to the immediately preceding cost reporting period only. This pollicy is based on the language in section 1886(d)(5)(C)(ii) which states that this additional payment is available "in the case of a sole community hospital that experiences, in a cost reporting period * * * compared to *the previous* cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases * * *" (emphasis added). Thus, if a hospital experiences an occurrence that results in a sustained decrease in cases, an adjustment would be made for the cost reporting period where the change occurred but would not be made during subsequent periods unless dicharges decreased another 5 percent.

Example: Hospital A loses its community physician during its cost reporting period ending September 30, 1984. This results in sustained lower case load until June 1986 when the physician is replaced.

- Discharges for cost reporting period ended September 30, 1983—5,000
- Discharges for cost reporting period ended September 30, 1984—3,000
- Discharges for cost reporting period ended September 30, 1985—3,500

An adjustment is available only for the cost reporting period ending September 30, 1984, even though discharges for the period ending September 30, 1985 were more than 5 percent less than the year immediately preceding the onset of prospective payments.

(ii) Amount of Payment Adjustment

The statute requires that the payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services.

Fixed costs are defined as those over which management has no control. Most true fixed costs such as rent, interest, and depreciation are capital-related costs and would be paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization. However, in a hospital setting many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but will also vary with volume. For purposes of this adjustment,

many semifixed costs, such as personnel related costs, may be considered as fixed on a case by case basis. An adjustment will not be made for truly variable costs, such as food and laundry services.

In evaluating semifixed costs, such as personnel, HCFA will consider the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs would be considered fixed. As the period of decreased utilization continues, we would expect that a cost-effective hospital would take some action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, we would not include such costs in determining the amount of the adjustment.

The statute also requires that the adjustment amount include the reasonable cost of maintaining necessary core staff and services. HCFA will review the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

iii. Procedures for Requesting Special Adjustments

Sole community hospitals that believe they qualify for an adjustment as explained above must submit a written request for an adjustment to HCFA through the intermediary. The request must clearly document the extraordinary circumstances causing the decrease in patient volume and its effect on costs.

The hospital's request must be made to its intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary will make a recommendation on the hospital's request to HCFA, which will make the decision. We will respond to the request, through the intermediary, within 180 days of the date we receive the request from the intermediary. HCFA's decision will be reviewable under the provisions of Subpart R of 42 CFR Part 405.

The Secretary is required to study and make legislative recommendations to the Congress by April 1, 1985, with respect to an equitable method of reimbursing SCHs which takes into account their unique vulnerability to substantial variations in occupancy.

2. Christian Science Sanitoria

There are approximately 22 Christian Science Sanitoria participating in Medicare. Patients in these institutions are allowed to determine whether the services they receive constitute hospital or SNF services. The basic prospective payment system clearly would be inappropriate for these facilities since they do not furnish the kind of medical services, particularly ancillary services, that are generally provided in acute care hospitals.

Therefore, if a Christian Science Sanitorium is not excluded from the prospective payment system under § 405.471 (e.g., by meeting criteria as a long-term hospital), HCFA will pay for inpatient hospital services furnished to a beneficiary by that sanitorium on the basis of a predetermined fixed amount per discharge based on the sanitorium's historical inpatient operating costs per discharge (see § 405.476(e)). For cost reporting periods beginning on or after October 1, 1983, the sanitorium's prospective payment rate will be equal to the amount that would constitute the sanitorium's target amount under § 405.463(c)(4) if the institution were subject to the rate of increase ceiling (at § 405.463) instead of the prospective payment system. This amount will not be adjusted for the DRG weighting factor. Additionally, a sanitorium is not eligible for outlier payments under § 405.475.

3. Hospitals Involved Extensively in Treatment for and Research on Cancer

Congress specifically mentioned hospitals extensively engaged in cancer treatment and research as a class of hospitals for which some exception might be provided. It is clear that the concern was limited to a few hospitals that are primarily devoted to cancer treatment and research. We could not identify hospitals engaged extensively in cancer treatment based on Medicare records because we do not approve hospitals based on the particular types of cases they treat.

We are able, however, to identify certain characteristics which need to exist in a hospital setting for it to fit the category described in the law. First, the primary mission of the hospital must be restricted to cancer care. Second, most of the cases treated by the hospital must be cancer cases, i.e., involvement must be extensive. Third, the hospital must have a substantial commitment to research on cancer.

Therefore we will define cancer hospitals as follows:

- The hospital must have been recognized by the National Cancer Institute of the National Institutes of Health as a comprehensive cancer center or clinical cancer research center as of April 20, 1983 (i.e., the date of Pub. L. 98-21 was enacted).
- The hospital must demonstrate that the entire facility is organized primarily for treatment of and research on cancer.
- 80 percent or more of the hospital's total discharges must be classified in those DRGs reflecting the condition of cancer as the principal diagnosis.

Hospitals meeting the above criteria will be given an opportunity, before their first cost reporting period begins under the prospective payment system, to opt for reimbursement on a reasonable cost basis subject to the target rate ceiling. If this option is chosen, they will have an additional option of converting to the prospective payment system at a future date. No further options will be allowed.

A number of hospitals have over the course of time devoted a major share of their attention to cancer treatment and research. These facilities, which play a significant role in the development of cancer treatment, represent an existing concentration of resources in the area of cancer care.

We believe Congress was concerned that the prospective payment system might produce an unintended disincentive for current programs if those institutions involved extensively in treatment of and research on cancer were found to be legitimately more costly than typical short-term general hospitals. Since the standardized amounts are based on expenditures in short-term general hospitals, a hospital could, under the circumstances, be encouraged to reduce its commitment to cancer treatment in order to operate within the prospective rate. Such a diminution of existing cancer programs would be an unintended negative consequence.

Additionally, we believe it is desirable to avoid the opposite effect. That is, we do not think it is appropriate for the system to become the chief determinant of whether existing resources will be shifted among broad classes of illness. We recognize the power of the prospective payment system to create incentives for particular actions and realize that hospitals might be encouraged to create duplicative programs if the system provided financial incentives.

In order to assure that cancer treatment and research are maintained while avoiding incentives for artificial expansion, we believe it is appropriate to focus our policy on current programs which might be limited or curtailed. This is, we think, consistent with the evident desire of the Congress to afford some level of protection to hospitals whose involvement in cancer treatment and

research over the years has been extensive.

Therefore, as stated in the first criteria above, we are restricting the special provision for cancer centers to those hospitals whose programs were recognized as of April 20, 1983.

4. Referral Centers

Section 1886(d)(5)(C)(i) of the Act states that "the Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas) . . ." The Conference Committee Report accompanying Pub. L. 98-21 contains little additional language clarifying what the Congress intended by "regional and national referral centers." The Report does state, however, that they include very large acute care hospitals in rural areas. In addition, since the law specifies "regional and national" referral centers it appears that Congress intended that such referral centers would serve a substantial number of patients outside the local area.

There is no commonly accepted definition of a referral center. However, we have developed criteria that we believe fulfill the intent of the law, and have included them at § 405.476(g) of these interim regulations.

To be considered a referral center, a hospital must be a short-term acute care hospital with a provider agreement in effect under Part 489 to participate in the Medicare program; and

a. The hospital must be located outside of any Metropolitan Statistical Area (MSA) or the New England County Metropolitan Area (NECMA) recognized by the EOMB and have at least 500 beds as defined in section 2510.5 of the Provider Reimbursement Manual; or

b. The hospital must have a patient population such that at least 60 percent of all Medicare patients reside out-of-State or more than 100 miles from the hospital (whichever is more stringent) and at least 60 percent of all services received by Medicare beneficiaries must be provided to Medicare beneficiaries residing out-of-State or more than 100 miles from the hospital.

The above criteria are considered appropriate as they clearly distinguish hospitals that are predominant for the purpose of referrals from other institutions. We wish to encourage comments on these criteria.

We believe that the few rural referral centers with 500 or more beds clearly require some recognition in their payments, and that they are not comparable to other rural hospitals. Generally, these hospitals offer a variety of specialized services, employ many specially trained personnel, and have a medical staff composed of many different types of specialists. In these factors and in the services they furnish, they are similar to urban acute care centers, and pay salaries and have costs comparable to those hospitals. Therefore, we will determine prospective payments to these hospitals on the basis of the urban, rather than rural, adjusted standardized amounts. (These amounts will be adjusted appropriately, as for any other hospital, by the applicable DRG weighting factor and the hospital's area wage index.)

Except for rural referral centers with 500 or more beds, there will be no adjustments made for referral centers during the first year of the transition period. We must first determine which facilities are affected. We do not believe that this interim period will present difficulties for referral centers for the following reasons.

- During the first year, 75 percent of the prospective payment rate will be based on the hospital's own experience (i.e., the hospital-specific portion).
- Hospitals may request additional payment for "cost-based" outliers.
- We expect that virtually all referral centers will be teaching hospitals which will benefit from the doubling of the teaching adjustment.

During the first six months of the first transition year, hospitals must submit written requests, including all data necessary for a determination based on the above criteria, to their fiscal intermediaries. The intermediaries will make a recommendation to HCFA which will make the final determination.

During the second six months of the first transition year, HCFA will, after analyzing all data submitted, make a judgement regarding any adjustments that may be appropriate for referral centers beginning with the second year of the transition period.

5. Hospitals with Disproportionate Numbers of Low Income Patients or Medicare Beneficiaries or Both

The statute authorizes the Secretary to make adjustments to the prospective payment rates in consideration of the special needs of certain classes of hospitals, including public or other hospitals that incur additional costs because they serve a significantly disproportionate number of low income patients or Medicare Part A beneficiaries. We have not made special provision for these hospitals in the regulations because our current data do not show that such an adjustment is warranted.

To date, we have conducted a preliminary analysis of Medicare inpatient operating costs per case adjusted for case-mix and, after considering other factors already recognized in the prospective payment amounts, have not found a significant association between higher Medicare cost per case and either public ownership or the proportion of low-income patients. (Using a ratio of Medicaid utilization as an indicator of low-income patients, we found no significant influence on costs per case.) Likewise, we have no indication that the volume of Medicare patients significantly affects a hospital's costs.

We have been consulting with representatives from the health care field on this issue and, in a joint effort with them, are conducting a review of the available data. Therefore, adjustments will not be made initially for hospitals with disproportionate numbers of low income or Medicare patients. If, after more detailed study, we find that adjustments are appropriate we will publish a notice in the **Federal Register** informing the public of the change.

6. Kidney Acquisition Costs Incurred by Renal Transplantation Centers

Kidney acquisition costs incurred by Renal Transplantation Centers (RTC) will be treated as an adjustment to prospective payment. Hospitals engaged in kidney transplantation encounter a unique set of circumstances with respect to their cost experience because of special provisions of the law applicable to End Stage Renal Disease (ESRD). Kidney acquisition costs are reimbursed under section 1881 which requires the Secretary to: (1) Reimburse the hospital for obtaining kidneys from Organ Procurement Agencies (OPA) in amounts not to exceed the costs incurred by OPAs and histocompatability laboratories; and (2) Reimburse the reasonable expenses incurred by an individual donor. In view of the unique characteristics of organ procurement activities and the desirability of maintaining an adequate supply of kidneys, we believe these costs should be handled outside of the prospective payment system. Therefore, payments to a hospital will be adjusted in each reporting period to compensate hospitals for reasonable expenses of kidney acquisition, and costs of this type will not be included in determining the prospective payments rates.

Kidney acquisition costs have been removed from the standardized amounts

and from the cost weight for DRG 302 (Kidney Transplant). An adjustment will be made to the RTC's base year costs to remove the estimated cost of kidney acquisition. Interim reimbursement for kidney acquisition costs incurred by RTCs will continue to be based on the average acquisition costs of the hospital. Final settlement will be made based on the hospital's cost report. Other hospitals that excise kidneys for transplant will no longer be paid for this activity directly by Medicare. They must receive payment from the OPA or RTC.

An adjustment to the RTC's operating costs, used to compute the average standardized amount, was made by estimating the kidney acquisition costs in the RTC using the unweighted average kidney acquisition costs. This average was first adjusted for area wages and indirect teaching costs. This standardized average kidney acquisition cost was multiplied by the number of kidney transplants for the RTC to obtain the kidney acquisition costs for the RTC. The operating ocsts were reduced by the kidney acquisition cost.

7. Other Exceptions and Adjustments

While the statute authorizes the Secretary to provide for exceptions and adjustments for any class of hospitals deemed appropriate by the Secretary, we are initially providing exceptions and adjustments only as discussed above. At the present time, we have no reason to believe that any other exceptions or adjustments are appropriate.

H. Appeals

For the most part, disputes that arise in connection with the prospective payment system will be resolved under the administrative and judicial appeals procedures and authorities already established under the Medicare program.

1. Beneficiaries

Pub. L. 98–21 left undisturbed those provisions of title XVIII of the Act that set forth processes for beneficiaries who pursue appeals of determinations with respect to matters such as entitlement to benefits or coverage of health care services under the Medicare program. Thus, the procedures described in Subparts G and H of 42 CFR Part 405 for beneficiary appeals will remain in effect under the prospective payment system.

In addition, the waiver of liability provisions of section 1879 of the Act, as implemented through regulations at §§ 405.330–405.332, continue to apply. In this regard, under section 1866(a)(1)(G) of the Act, hospitals that are receiving payment under the prospective payment system must agree not to charge beneficiaries for inpatient hospital services that are furnished to beneficiaries under the system but for which the hospital is denied payment under section 1886(f)(2) of the Act. Under this latter section, if HCFA makes a determination that a hospital has taken an action that results in an unnecessary admission of a Medicare Part A beneficiary or unnecessary multiple admissions of the same individual or other inappropriate practice with respect to the individual in order to circumvent the prospective payment system, HCFA may deny part or all of the payment for the services furnished by the hospital in connection with the unnecessary admission. HCFA may also require the hospital to take corrective action to prevent or correct the inappropriate practices. Whatever action is taken by HCFA in either of these circumstances, the hospital will already have agreed not to hold the beneficiary liable for the costs of the services, and the beneficiary may not be charged regardless of fault.

2. Hospitals.

With regard to appeals by hospitals, the jurisdiction of the Provider Reimbursement Review Board (hereafter referred to as "the Board") under section 1878 of the Act will apply generally to questions concerning payments to hospitals arising under prospective payment. For other types of questions, different appeal procedures will apply. In addition, we have determined that the waiver of liability regulations at §§ 405.330–405.332 will apply if an entire patient stay, a "day outlier", or a "cost outlier" (as discussed in section III.H. of this preamble), is denied under section 1862(a)(1) or (9) of the act because health care services were found to be not medically reasonable and necessary or to constitute custodial care. Section 1879 waiver of liability considerations will also apply if a PSRO/PRO or FI finds that services are not payable. Therefore, we changed the regulations in 42 CFR Part 405, Subpart G (which contains procedures for appeals under Part A of Medicare) to govern appeals stemming from individual claims determinations, accordingly.

Essentially, there are three areas of hospital appeal procedures that must be addressed in this final rule.

a. The Board

To be reimbursed for services covered by the Medicare program, providers generally have been required to file cost reports with their fiscal intermediaries. These reports are used by the intermediaries to determine the amount of program reimbursement due to the provider for health care items and services furnished to beneficiaries. If a provider is dissatisfied with the amount of reimbursement (or if the intermediary does not make its determination within 12 months after receiving a cost report), and the amount in controversy is $10,000 or more, the provider has the right under section 1878 of the Act to request a hearing before the Board. The provider must meet specified time limits for filing an appeal. In addition, the Administrator and Deputy Administrator of HCFA have been delegated the authority by the Secretary under section 1878(f) of the Act to reverse, affirm, or modify a decision of the Board on his or her own motion.

If a provider is dissatisfied with the Board's decision or, if the decision has been reviewed by the Administrator or Deputy Administrator and the provider is dissatisfied with that decision, the hospital may request judicial review of the final decision by a U.S. District Court. (In certain cases, the hospital may appeal directly to a U.S. District Court when the Board determined that it does not have the authority to decide the questions appealed.)

In the exercise of its review authority, the Board decides all questions relating to its jurisdiction to grant a hearing.

Except for the restrictions (discussed below) contained in section 1886(g)(2) of the Act, as added by Pub. L. 98–21, appeal procedures for hospitals receiving payments under the prospective payment system are basically the same as for all providers being reimbursed on the basis of reasonable cost. Under section 1878(a) of the Act, as amended by section 602(h) of Pub. L. 98–21, hospitals receiving payment under the reasonable cost subject to the target rate system (section 1886(b) of the Act) and hospitals receiving payment under the prospective payment system may obtain a Board hearing with respect to the payments if—

- The hospital has submitted required reports;
- The amount in controversy is $10,000 or more; and
- The hospital files its appeal within 180 days after receiving notice of "the Secretary's final determination . . ."

Other amendments to section 1878 of the Act by Pub. L. 98–21 are as follows:

- Section 1878(f)(1) was amended to provide that in a civil action brought jointly by several providers, the suit may be brought in the judicial district in which the greatest number of such providers are located. This section was further amended to provide that an

appeal to the Board or the courts by providers that are under common ownership or control must be brought by the providers as a group with respect to any matter involving an issue common to the providers. Before Pub. L. 98–21 was enacted, providers were limited to bringing joint civil actions in the judicial district in which all the providers were located, or in the U.S. District Court in Washington, D.C.

• Section 1878(g)(2) was added to the Act to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:

—A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or

—The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost.

It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98–25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

In order to implement these changes, we have included in this final rule amendments to 42 CFR Part 405, Subpart R, Provider Reimbursement Determinations and Appeals.

i. To implement the changes to sections 1878(a) and (g)(2) of the Act contained in Pub. L. 98–21, it was necessary to amend the following sections of the regulations:

• In § 405.1801, we expanded the definition of "intermediary determination" (and also made conforming changes in § 405.1803) to include a determination as to the total amount of payment under the reasonable cost subject to the target rate system or under the prospective payment system due a hospital for the cost reporting period covered by the determination. For purposes of appeal to the Board, the definition is synonymous with the "final determination of the Secretary," as that term is used in section 1878(a) of the Act.

• In § 401.1801(c), we stated that the prospective payment appeals regulations will be effective with a hospital's first cost reporting period under the Medicare program beginning on or after October 1, 1983.

• We added a new § 405.1804 (and also made conforming changes in § 405.1873 and § 405.1877) to describe the matters that are not reviewable by the Board or by the courts as provided in section 1886(d)(7) of the Act.

• For purposes of determining the amount in controversy in a particular period, we expanded § 405.1839 by providing that the amount will include amounts computed by deducting the total amount due the hospital under the target rate or prospective payment system from the total amount that would be payable to the hospital after taking into consideration any exemption, exception, exclusion, adjustment or additional payment originally denied the hospital under § 405.463 or §§ 405.470–405.477, as applicable, but disputed by the hospital in its request for a hearing.

• We made conforming changes in other sections of 42 CFR Part 405, Subpart R as necessary to incorporate references to the intermediary's determination and notice about prospective payment.

ii. With certain changes, the regulations at § 405.1837 (Group appeal), § 405.1841 (Time, place, form, and content of request for Board hearing), and § 405.1877 (Judicial review) are consistent with and can accommodate the Pub. L. 98–21 amendments to section 1878(f)(1) of the Act. These amendments were effective April 20, 1983, the date on which they were signed into law. The statute is self-implementing and our changes are merely conforming regulations. Thus, the regulations specify the effective date of the statute, and will apply to an appeal to the Board or an action for judicial review filed prior to the publication date of the final regulations, as well as those filed after the publication date. Under the amendment to section 1878(f)(1) of the Act concerning providers under common ownership or control, we have changed the regulations to state that effective April 20, 1983, an appeal to the Board or an action for judicial review by providers that are under common ownership or control, as that phrase is defined in § 405.427 of the regulations, must be brought by the providers as a group with respect to any matter involving an issue common to them. Section 405.427 states that common ownership exists if an individual or individuals possess significant ownership or equity in the provider and in the institution or organization serving the provider. Control exists if an individual or an organization has the power, directly or indirectly, to influence significantly or to direct the actions or policies of an organization or institution whether or not that power is actually exercised. Under the amendment concerning judicial review venue, we further changed § 405.1877 to add a third permissible venue, effective April 20, 1983, in the case of a civil action brought jointly, by several providers, that is, the judicial district in which the greatest number of the providers is located.

b. Errors in DRG Coding

As noted above, it is clear that Congress intended hospitals to be entitled to a review of DRG classifications if errors occur concerning the coding of an individual patient's case.

Intermediaries will assign discharges to DRGs initially. Where errors in coding occur, the hospital may resubmit the billing data with the revised coding for the case. Additionally, the hospital may request individual review of claims. The review would appropriately be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination. However, in general, the DRG classification system may not be appealed.

We are presently developing a proposed rule, to be issued in the **Federal Register** in the near future, to deal with PRO hearings and appeals.

c. Outlier claims

A hospital's claim for outlier payments will be subject to review by a peer review organization (PSRO/PRO) under Part B of Title XI of the Act, or in their absence, the hospital's fiscal intermediary, which will make appropriate coverage determinations. The PSRO/PRO or the intermediary will examine outlier cases and will deny claims for additional payment for those days of care in the outlier case that are not covered. (See the more detailed discussion of PSRO/PRO or intermediary review in section III. J. of this preamble.).

An adverse PSRO/PRO coverage determination may be challenged by the provider under the authority of section 1155 of the Act, which provides for a

reconsideration of the issue by the PRO. However, a provider may not appeal the PRO coverage determination beyond the reconsideration stage. On the other hand, for denials under section 1154, section 1879 of the Act gives the provider the same appeal rights as a beneficiary concerning whether it knew that the services were not covered. If section 1879 considerations are applicable, the provider may request, as part of the appeals process authorized under § 405.704(b)(12) of the regulations, a reconsideration, a hearing before the Office of Hearings and Appeals of the Social Security Administration, and judicial review. Accordingly, we amended § 405.704(b)(12) to provide that, if items or services for which payment could otherwise be made under section 1886(d)(5)(A) of the Act are excluded from coverage based on a determination that the services are not medically necessary, constitute custodial care, or are excluded under section 1154(a) (1) and (2), and a determination is made under section 1879 as to whether the hospital knew or could reasonably have been expected to know the items or services were excluded, the section 1879 determination is appealable.

I. Charges to Beneficiaries

Except as described below, a hospital may not charge a beneficiary for services covered under the Medicare program. However, Medicare Part A beneficiaries are responsible for payment of deductible and coinsurance amounts. The deductible is a set amount of inpatient hospital costs for which the beneficiary is liable when he or she first enters the hospital during a benefit period. Under Medicare, coinsurance is a daily charge for inpatient hospital care for which the beneficiary is liable after he or she has been hospitalized for 60 days. These amounts are changed each year as required by law.

Generally, a hospital paid under the prospective payment system must bill its intermediary, under Medicare Part A, for all inpatient hospital services furnished to a beneficiary. Except as described below, a hospital may not bill either a beneficiary or Medicare Part B for services for which payment is made under the prospective payment system. However, in cases in which no payment is made under the prospective payment system for inpatient hospital services (either because a beneficiary's Medicare Part A benefits were exhausted before admission to the hospital, or because the inpatient admission was denied as not covered), a hospital may seek payment for those specific services which can be covered under Medicare Part B, if the beneficiary is entitled to have the service paid for under Part B.

In addition, a hospital furnishing inpatient hospital services to a Medicare beneficiary for which it expects to receive payment under the prospective payment system may charge the beneficiary for certain items and services for which payment is not made by Medicare. These items and services include:

- Items and services, furnished at any time during the stay, which are excluded from coverage on some basis other than § 405.310(g), (k), and (m) (i.e., as custodial care, medically unnecessary items and services, and nonphysician services furnished to hospital inpatients by other than a hospital or a provider or supplier under arrangements made by the hospital).
- Days of care subsequent to a length-of-stay outlier (as described in § 405.475(a)(1)) which:

—Will not be paid for by Medicare because the patients' benefits under Medicare have been exhausted, or
—Are not covered under Medicare Part A for other reasons and waiver of liability under § 405.330 does not apply. When payment is considered for outlier days, the entire stay will be reviewed and days up to the number of days by which the total stay exceeds the day-outlier threshold may be denied. In applying this rule, the latest days of the stay will be denied first. However, unless the entire stay is denied, the basic prospective payment rate will not be affected.
—Items and services attributable to cost-outliers which will not be paid for by Medicare because the services are not covered and waiver of liability under § 405.330 does not apply. (Exhaustion of benefits during the stay will have no effect on cost-outliers.) When payment is considered for cost-outliers, the coverage of services throughout the stay will be reviewed. When payment for services is denied solely on the basis of § 405.310(g) or (k) (i.e., custodial care and medically unnecessary items and services), the amount which the beneficiary may be billed for the denied services is limited to an amount which, when added to the Medicare payment for the stay, results in a total payment for the stay no greater than the Medicare payment would have been had all the denied services been viewed as covered.

- The customary charge differential for a private room or other luxury item or service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or that of the person acting on his or her behalf).

Under section 1866(a)(2)(B)(ii), a beneficiary could also be charged, if certain conditions were met, for costs in excess of the cost limits, established under section 405.460. Section 1866(a)(2)(B)(ii) was amended, however, by section 602(f)(2) of Pub. L. 98-21 to provide that these charges may not be imposed for services provided under the prospective payment system. Except as indicated above with respect to luxury items and services, a hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing those services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

As noted above in the discussion about beneficiary appeals, Congress provided in section 602(f)(1) of Pub L. 98-21 that beneficiaries may not be held responsible for charges for services furnished by a hospital in connection with unnecessary admissions, unnecessary multiple admissions, or inappropriate medical or other practices. To implement this provision, we have amended § 489.21 of the regulations. This section describes specific limitations on charges that a provider may impose on a beneficiary. We state in a new § 489.21(e) that, as part of its agreement with the Secretary under section 1866 of the Act, the provider (in this case, a hospital under prospective payment) may not charge a beneficiary for inpatient hospital services for which the beneficiary would be entitled to have payment made but for the improper practices of the provider with respect to admissions or other inappropriate medical practices.

J. Review Activities

1. Medical Review

a. Medical Review Agents.

The conforming amendments contained in Section 602 of Pub. L. 98-21 require hospitals receiving Medicare payments to enter into an agreement with a Utilization and Quality Control Peer Review Organization (PRO) by October 1, 1984. Until a PRO contract is awarded in an area, medical review will be conducted by existing Professional Standards Review Organizations (PSROs) or fiscal intermediaries, absent a federally funded PSRO in the area.

As a result of PRO contracts being awarded over the course of FY 84 (i.e., October 1, 1983 through September 30, 1984), the medical review role will be spread between the above mentioned

entities. Therefore, for the sake of clarity, we will use the term "medical review agent", which will encompass the entities listed above.

b. Background

The Social Security Amendments of 1983 did not modify the statutory provisions that prohibit Medicare from paying for certain care. For example, the law retains the following technical exclusions providing that Medicare will not pay:

- For hospital care when the patient has no legal obligation to pay (section 1862(a)(2) of the Act);
- When another government entity pays (section 1862(a)(3) of the Act); or
- When payment may be made under worker's compensation, an automobile medical liability, no fault insurance, or an employer's group health plan that is primary insurance for an ESRO beneficiary or an employed beneficiary or spouse age 65 to 69 (section 1862(b) of the Act).

Also, the law retains requirements that no payment be made for the following: services that are not certified by a physician as needed services (section 1814(a)(2) of the Act), services that are not reasonable and necessary (section 1862(a)(1) of the Act), services that constitute custodial care (section 1862(a)(9) of the Act), and services that are personal comfort items (section 1862(a)(6) of the Act).

We need to adjust our policies for excluding payment for such noncovered care to reflect Medicare's shift in reimbursement policy. Prior to the recent amendments, the financial incentives of cost-based reimbursement built in logical assumptions that there might be a tendency on the part of providers to overutilize services, thus leading to increases in their costs associated with treating Medicare patients. Now, however, aside from the potential for inappropriate admissions, the incentives work in the opposite direction in that, regarding inpatient operating costs for which payment is made under the prospective payment system, hospitals are benefited *only* if they provide solely those services needed to care for the patient in an appropriate manner. Therefore, it is essential that we reshape some of our approaches to identifying noncovered care so that they reflect the realities of the new system of payment.

It is our intent to describe review methods and policies necessary to avoid payment for noncovered care that will apply to all HCFA medical review agents. We are continuing to consider alternative proposals and we wish to encourage comments on these provisions.

c. General Policies and Assumptions

Specifically, we will apply the following coverage principles under prospective payment:

i. Technical Exclusions

We will not change our implementation of the statutory "technical" exclusions. Generally, those exclusions are absolute and not sensitive to fiscal incentives built into the new payment policies. Therefore, no changes will be made in provisions such as §§ 405.311–405.314.

ii. Physician Certification

Adjustments will be made to the implementation of physician certification requirements in section 1814(a)(3) of the Act so that physicians must certify at new "key" points where payment incentives could lead to inappropriate utilization (i.e., at what the hospital reasonably assumes to be the beginning of outlier status for a case and, as appropriate, during that outlier status).

iii. Medically Related Coverage

Adjustments will be made to the procedures for enforcement of medically-related coverage provisions in a way that focuses on whether admissions were appropriate and otherwise covered (i.e., reasonable and necessary and not for the purpose of delivering statutorily or otherwise excluded care), with further review being conducted only in outlier cases.

iv. Operational Assumptions

One operational assumption inherent in these adjustments and approaches is that once an admission has been found to be covered (i.e., it was a reasonable and necessary admission for the particular patient and it was not for the delivery of statutorily or otherwise excluded care, (e.g., for cosmetic or experimental care), *any* services or days needed by and provided to a beneficiary are included in the Medicare prospective payment rate and that it is these services which the hospital has provided. This based on the realities of the new fiscal incentives involved.

d. Review and Denials System

i. For Technical Exclusion

FIs will continue their current system of ensuring no Medicare payment where these exclusions apply. We are making no changes in §§ 405.311–405.314.

At present, we will continue to require FIs to review for care not reasonable and necessary based on *national* coverage policy and, where medical judgments are required to implement national coverage provisions, to use PSROs or PROs to make those judgments. For example, Medicare does not pay for procedures or services which have not been proven to be safe and effective (i.e., for services which are generally experimental in nature). The program denies such payment on "reasonable and necessary" grounds. This policy will continue and FIs will continue to be ultimately responsible for this enforcement (deferring to PSROs or PROs as noted above), although, as in the past, PSROs/PROs will be expected to consider such policies when performing their case-specific admission and outlier review.

Therefore, as in the case of PSRO/PRO review, payment for nonoutlier cases will be totally denied or totally approved based on a finding regarding the appropriateness of the admission. When an FI finds, in conducting retrospective review, that the sole or primary services provided to a patient above and beyond routine services were experimental and therefore noncovered (as enumerated in program instructions), the patient's admission will be found to have been inappropriate and payment for the entire stay will be denied.

Continuation of our current policy will generate a substantial incentive for providers to adhere to generally accepted medical practices in their treatment of Medicare patients. Therefore, to avoid potential payment loss, providers must remain sensitive to and cognizant of "nationally" noncovered care.

It should be noted in this regard that only if the *sole or primary* services (beyond routine care) provided to a patient are noncovered will the admission (and therefore prospective payment) be denied. This means that as long as an acceptable or proven diagnostic or treatment course (for the DRG) is present, even if noncovered care is also present, the payment will be made.

ii. Specific Review

We will specify in PRO contracts, the process by which PROs will meet the review requirements under prospective payment. Until a PRO contract is awarded in an area, the PSRO or FI will perform the following review functions.

A. Admission Review

After finding that an admission is appropriate, the medical review agent will not "carve out" days or services to affect the DRG rate portion of a prospective payment, based on findings of overutilization occurring in a nonoutlier case. This will be the

approach because the absence of such noncovered care will be presumed based on the fiscal incentives involved and the assumption that DRG rates are set at a level to pay only for care essential to treat the patient and delivered in the most appropriate setting.

If the medical review agent finds that the admission is inappropriate, it will deny the admission, and the hospital would not receive DRG payment.

B. Admission Pattern Monitoring

Under TEFRA, HCFA put in place an admission pattern monitoring (APM) plan which will continue under the prospective payment system. Based upon a file of all Medicare discharges, HCFA compares the number of discharges from a provider during a quarter to the number of discharges from the provider over the previous eight quarters. If the percent of increase in discharges exceeds a predetermined threshold, the information is sent to the medical review agent for analysis.

If the medical review agent's data analysis cannot justify the increase in discharges, then medical review of discharges during the quarter in question takes place. The review is performed at the hospital using, at a minimum, an accepted random sample technique. The purpose of the review is to determine if the admission was medically necessary and appropriate.

C. Outliers

Once a case becomes an outlier, medical review policy and systems will shift to a mode designed to carve out unnecessary services or days. For day outlier cases, the medical review agent would deny unnecessary days, not specific services. Should the medical review agent find that noncovered treatment occurred in an appropriately admitted outlier case, the appropriate prospectively determined payment will be made for that DRG, and the specific noncovered days or services will be carved out of the outlier payment or, if appropriate, the entire outlier payment will be denied.

1. Day Outliers

Day outliers constitute one of the two types of outliers recognized under prospective payment. They are cases involving unusually long stays and result in per diem payments beyond the DRG rate for each day exceeding a specified number of days (i.e., for each day exceeding the day-outlier threshold criteria for the DRG) on which covered care is provided. Day-outlier cases occur automatically when a stay exceeds a specified number of days for each DRG. The determination of eligibility for extra Medicare payment is "automatic" for outlier days (i.e., a hospital need not specifically request it) and, therefore, appropriate medical review agent review of the day-outlier cases must occur.

When medical review occurs for the purpose of affecting payment for day outlier cases, that review includes: (1) reviewing to determine that the admission was medically necessary and appropriate; (2) "looking back" at the days occurring prior to the day outlier threshold being met (particularly unnecessary preprocedure or pretesting delays occurring at the beginning of the hospital stay or just prior to outlier status); (3) reviewing for unnecessary or excessive days actually occurring after the case reaches the day outlier threshold criteria; and (4) ascertaining that the diagnostic and procedural coding area reflective of the information found in the medical records.

If the medical review agent finds the patient's entire hospitalization to be reasonable and necessary, the hospital will receive the outlier payment. If the medical review agent's finding is negative, it will appropriately deny days of outlier payment. These denials will be subject to waiver of liability considerations under section 1879 of the Act.

2. Cost Outliers

Cost outliers, the other type of "unusual" cases under prospective payment, are recognized as such only if they are not eligible for payment as day outliers. They are cases where payment can be made beyond the prospective payment rate because extraordinary costs are incurred in a short period of time in treating the patient. Medicare payment beyond the prospective rate for that DRG would not be made until a certain threshold of "excess" costs above the amount of the prospective payment rate is reached, and Medicare would then pay only a certain percentage of costs incurred *beyond* that threshold point. Review by a medical review agent for noncovered services would occur whenever a hospital requests cost outlier payment. (Note that cost outliers, unlike day outliers, are not paid automatically. Hospitals must request cost outlier payment.) That review would include the monitoring of outlier services and, like day outliers, also involve "looking back" at the medical necessity and appropriateness of the admission as well as the previously provided services to determine whether they were noncovered (including their appropriateness). The medical review agent would also validate that the diagnostic and procedural information listed was substantiated by the medical records and that all charged services were actually rendered, ordered by a physician, and not duplicatively billed. Costs of unnecessary and otherwise noncovered services would be excluded both for purposes of determining arrival at the cost outlier threshold (i.e., by excluding costs for noncovered services occurring between admission and the point at which the request is made) and determining the amount of outlier payment (i.e., by excluding costs for noncovered care occurring between the outlier threshold and the end of care).

For cost outliers, the medical review agent review will be for the purpose of denying unnecessary services, rather than days. If the medical review agent approves the services, outlier payment will be made. If, however, it finds the services unnecessary, payment would be denied for some or all of the services (i.e., for noncovered care provided before cost outlier status, as identified by the hospital, for noncovered services actually generating outlier costs, or both). These denials also will be subject to waiver of liability considerations under section 1879 of the Act.

D. DRG Validation

To assign a DRG to a case the following elements must be present: principal diagnosis, secondary diagnoses (if any), names of surgical procedures (if applicable), age, sex, and discharge destination of the beneficiary. As a requirement for prospective payment, we are requiring that, shortly before, at or shortly after discharge (but before a claim is submitted), the attending physician will attest in writing to the principal diagnosis, secondary diagnoses, and procedures performed, to be utilized when assigning the DRG.

The medical review agent will review, at the hospital, at a minimum a random sample of discharges every quarter. The purpose of the review will be to ascertain that the diagnostic and procedural coding used to assign the DRG are substantiated by the medical records.

iii. Waiver of Liability

It is important to note here that, as discussed above in section III. E. of this preamble, the waiver of liability regulations (§§ 405.330–405.332) will apply if an entire patient stay or a day or cost outlier is denied under section 1862(a) (1) or (9) or 1154(a) (1) and (2) of the Act.

iv. For Other Medically-Related Statutory Exclusions (e.g., Foot Care, Dental Services, Cosmetic Surgery, and Personal Comfort Items)

We will continue to hold FIs responsible for monitoring for the presence of these statutory exclusions. When these coverage rules require the use of a medical judgment in their application, a PRO/PSRO must be used to make the medical necessity decision.

However, for purposes of prospective payment, FI's will assume that the cost of any noncovered care identified in a nonoutlier case has already been excluded by the process by which the prospective payment rate was developed. They will make full payment of that rate, unless, as in the above discussion, that assumption is not a reasonable one because the primary or significant nonroutine care provided was noncovered; in which case the admission will be denied and total prospective payment is to be denied.

On the other hand, if these noncovered items (e.g., personal comfort items, foot care) are identified in the review of an outlier case, the intermediary is to carve out appropriately from the outlier payment, consistent with the amount of noncovered care identified. Again, this would be day denials in day outliers (when it is clear that the days were solely or primarily for the delivery of noncovered care) and services denials for cost outliers.

e. Provisions of Interim Regulations

Under the prospective payment system, we are concerned that hospitals may be able to circumvent the intent of the system by unnecessarily admitting or readmitting individuals. Sharing this concern, Congress provided in Pub. L. 98–21 a new section 1886(f)(2) of the Act, requiring that:

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

Section 1886(f)(3) continues by specifying that the provisions of sections 1862(d) (2), (3), and (4), apply equally to determinations under section 1886(f)(2), and section 602(f)(1) of Pub. L. 98–21 adds a new paragraph (F) to section 1866(a)(1) of the Act.

Sections 1862(d) of the Act contains general provisions prohibiting fraudulent billing practices and provision of unnecessary services, or services that fail to meet professionally recognized standards and provides for notice to providers and suppliers, the public, and State Medicaid agencies when it is determined that such practices have occurred. Section 1866 sets forth the requirements of provider agreements, which must be complied with for a provider to participate in Medicare.

It is clear from these provisions that Congress wished to provide strong sanctions against circumventing the prospective payment system. However, section 1886(f)(2) determinations must, according to the statutory language, be based upon the findings of a PRO. We are implementing prospective payment under section 1886(d) before any PRO regulations become effective or any PRO contracts established. Nonetheless, it is clear that we must have regulations in place providing for admissions review at the very inception of the prospective payment system.

We are providing, in § 405.472(e), general regulations setting forth review requirements modeled after the requirements of sections 1862(a), 1862(d), and 1886(f)(2), establishing general authority for HCFA to impose sanctions based on this review, and cross-referring to appropriate regulations providing for notice and appeal.

In § 405.472(e)(2), we are providing for appropriate procedures when payment is denied in individual cases, depending on whether the denial was the result of review by a PRO, PSRO, or fiscal intermediary. In §§ 405.472(e) (3) to (5), we are providing appropriate procedures when review shows a pattern of inappropriate admissions or billings that have the effect of circumventing the prospective payment system. Such cases would come under the Medicare quality review regulations at 42 CFR Part 420, and could result in termination of a hospital's provider agreement.

We do not intend these interim regulations to implement section 1886(f)(2) (or the provisions of 1866(a)(1)(F) concerning agreements between hospitals and PROs and per case payment for PRO reviews). Those statutory requirements will be implemented at a later date under the PRO regulations. Rather, under the authority of sections 1102, 1862(d), and 1876 of the Act, we are establishing the regulatory authority that we believe, at a minimum, is required to ensure that timely implementation of payment under 1886(d) does not result in incentives, loopholes, and payment outcomes clearly contrary to the intent of Congress.

We expect, initially, that we will implement these regulations through fiscal intermediary and PSRO review. After PRO regulations, and regulations explicitly implementing section 1886(f)(2), are in place, we would expect these functions to be taken over by PROs.

2. Utilization Review

a. Discussion

For hospitals under prospective payment, Congress has retained the requirement that Medicare hospital providers have a utilization review (UR) committee, which operates in conformance with certain statutory provisions (section 1861(k) of the Act). For hospitals under PSRO review, this statutory requirement does not apply. In regulations now being developed for hospitals under PRO review, we plan to propose similar exceptions. Currently, another statutory provision, section 1866(d), further privides that no Medicare payment will be made beyond a certain point in "long stay" cases (i.e., no payment beyond 20 days) if the Secretary has found inadequate UR compliance (Also see section 1814(a)(6) of the Act). And, finally, section 1814(a)(7) of the Act provides that program payment cannot be made if a hospital UR committee has found that further care is not necessary, except that up to 3 grace days may be provided.

Hospitals covered by section 1861(k) of the Act must comply with the basic terms of the statute and a partial set of implementing regulations, parts of which have been permanently enjoined. (See *AMA et al. v. Weinberger*, 395 F. Supp. 515 (N.D. Ill., 1975), affd. 522 F. 2d 921 (7th Cir., 1975).) The proposed new UR regulations appearing in the proposed rule, *Conditions of Participation for Hospitals*, published in the January 4, 1983, **Federal Register** (48 FR 299), impose basic requirements which adhere closely to the statute. Essentially, the requirements that hospitals would have to meet include:

- Having an UR committee;
- Reviewing admissions and durations of stay;

• Reviewing extended stay cases no later than 7 days after specified time intervals; and

• Notifying parties of denials.

b. Changes to the Regulations

i. For purposes of prospective payment, we are revising 42 CFR Part 405, Subpart J, Conditions of Participation, Hospitals, by adding a new condition § 405.1042—Condition of Participation: Special Utilization Review Requirements for Hospitals Paid Under the Prospective Payment System. The changes contained in this new condition represent, for hospitals under the prospective payment system, a revision and adoption of the proposed § 482.30 on utilization review that appeared in our proposed regulations for hospital conditions published on January 4, 1983.

The comments we received on proposed § 482.30, and the changes in this provision that we made based on these comments, are discussed below. We are publishing this material in this interim final rule, rather than in a separate final rule on the hospital conditions of participation, because this will enable us to revise our utilization review requirements to reflect changes required by the prospective payment legislation. In addition, we believe prompt publication is justified because the new utilization review requirements will allow hospitals greater flexibility, and impose a lesser compliance burden, than our current regulations. This special condition becomes effective when each hospital begins participation in the prospective payment system. The current regulation at § 405.1035 on utilization review will continue to apply to all other hospitals participating in Medicare.

This special condition is an interim rule intended to contribute to the implementation of the prospective payment system. Comments on these interim rules will be responded to in the final rules on prospective payment that the law requires us to publish by December 1983.

Some comments received in response to the January, 1983 proposed rule are reflected in these special requirements. Therefore, a summary of our response to them is appropriate here.

Services for Which Review Is Required

Comment: Several commenters suggested that the opening paragraph of this section be revised to specify that services furnished by members of the medical staff of the institution, as well as by the institution, are subject to review. They also suggested that the term "individual" be changed to "patient," to avoid misunderstanding.

Response: We agree, and have revised this paragraph accordingly under § 405.1042.

Composition of Utilization Review Committee

Comment: Several commenters recommended that we require the utilization review (UR) committee to be composed of two or more fully licensed physicians (Doctors of Medicine or Osteopathy), rather than of two practitioners who meet the proposed definition of "physician." These commenters believe that only MDs and DOs are qualified to review the medical necessity of services to hospital patients, and that other practitioners included in the proposed definition of "physician" are not qualified to perform review responsibilities independently. One commenter suggested that if proposed § 480.30(b) and the proposed definition of physician were implemented without change, services furnished by MDs and DOs could be reviewed by other practitioners. Other commenters recommended that we require that at least one MD or DO be on each utilization review committee.

Response: This provision of our regulations implements section 1861(k) of the Act (42 U.S.C. 1395x(k)). Section 1861(k)(1) provides, in pertinent part, that the utilization review committee of a hospital or skilled nursing facility is to be "composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section) * * *". Section 1861(r)(1) defines a physician as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. To comply with these statutory provisions, we have specified in the regulation that a hospital UR committee must be composed of two or more physicians, of whom at least two must be doctors of medicine or osteopathy. Thus, we have adopted the first comment. However, we have not specified the review responsibilities of various categories of practitioners. As explained more fully below, specificity on this issue is not required by section 1861(k) and could unnecessarily limit hospitals' flexibility in complying with the UR requirements.

Comment: Some commenters suggested that we require, rather than merely permit, participation by non-physician health care personnel on utilization review committees. These commenters argue that if services of these personnel are available in the hospital, the personnel should participate in review of those services. In particular, one commenter suggested that an RN be required on the utilization review committee.

Response: Section 1861(k)(1) permits, but does not require, participation on UR committees by non-physician personnel. We believe it would be inappropriate to restrict by regulation a hospital's discretion with regard to inclusion of these personnel on UR committees. Therefore, we have not modified this provision to require participation by non-physician health care personnel in UR committee decisions. For the same reason, we have not required RN participation on the UR committee.

Comment: Some commenters stated that the prohibition against conduct of reviews by a physician who is financially interested in the hospital is unnecessarily broad (proposed § 482.30(b)(3)(i)), since all physicians who practice in a hospital have a stake in its financial well-being. They suggested that we prohibit review by physicians with a direct financial interest, such as an ownership interest.

Response: We agree, and have specified this provision that reviews by physicians who have a direct financial interest (e.g., an ownership interest) in the hospital are prohibited.

Comment: One commenter suggested that the regulation be modified to ensure that services of practitioners in a particular category would be reviewed only by other practitioners in the same category.

Response: We have not adopted this comment. This type of review procedure is not specifically required by section 1861(k) of the Act, and we believe that requiring the procedure in regulations would unnecessarily limit hospitals' flexibility in conducting utilization review.

Final Determination Regarding Admissions or Continued Stays

Comment: One commenter stated that it is unnecessary to require the UR committee to consult the attending physician and give him or her the opportunity to present his or her view before making a final determination that an admission or continued stay is not medically necessary. This commenter suggested that such a consultation could lead the attending physician to order additional, unnecessary services in order to justify the admission or stay. This commenter also expressed the view that the procedures for making negative determinations is too burdensome and that, rather than providing for grace days, HCFA should put more emphasis on discharge planning. On the other hand, another commenter suggested that

we require the UR committee to notify the patient as well as the attending physician before making a final determination that a continued stay is not necessary. This commenter believes that this notice would help ensure that attending physicians present their views regarding the need for continued stay to the UR committee, and thus would be an important safeguard against premature discharge.

Response: We have not adopted either comment. While requiring the UR committee to consult the patient's attending physician before making a final determination may delay the determination somewhat, we believe this consultation is essential to ensure accurate medical decisions regarding the need for admissions or continued stays. On the other hand, we do not believe that it is necessary to require UR committees to give separate notice to the patient before making final determination that continued stay is not necessary. This decision is a medical judgment that is made by the UR committee after consultation with the patient's attending physician, and we believe requiring notice to the patient would not increase the accuracy of the judgment.

We do not believe there is any incentive for a physician to order unnecessary services in order to justify a stay to the UR committee. Part of the committee's function is to identify unnecessary services, and such an attempt would be readily identified during the course of review. Moreover, the physician does not stand to gain anything by such action.

Comment: One commenter objected to the proposed utilization review provisions, since they do not permit the patient's attending physician to make the final decision as to whether a continued stay is medically necessary.

Response: The utilization review provisions are needed to implement section 1861(k) of the Act. This section requires the utilization review committee to review the duration of stays in the hospital and to give notification if it finds that further stay is not medically necessary. We have provided in the interim final rule that this decision is to be made only after consultation with the attending physician. We believe this provision is adequate to ensure that the attending physician's views are taken into account before a decision is made.

Comment: Some commenters suggested that we require all decisions regarding admissions and continued stays to be made by a minimum number of MDs or DOs (i.e., either one or two).

Response: As noted earlier, section 1861(k) specifies that decisions regarding admissions and continued stays may be made by a staff committee composed of two or more physicians, of whom at least two are MDs or DOs. The statute does not further require that only MDs or DOs may make decisions regarding admissions or continued stays. We do not believe it would be either necessary under the statute, or consistent with hospital flexibility, to impose such a further requirement in our regulations.

Comment: One commenter stated that our proposal to remove many credentialling requirements from other areas of the hospital conditions would reduce the quality of UR in hospitals, since many of the affected personnel are involved in UR.

Response: We are continuing to analyze the issues raised with regard to credentialling, and have not yet made final decisions on these issues. However, we have not seen any evidence to indicate that our credentialling proposals would adversely affect UR activities in hospitals. Therefore, we have not adopted any changes based on this comment.

Comment: One commenter suggested that we require UR to be conducted to determine the "health care necessity" rather than "medical necessity" of services. This commenter, a State nursing association, stated that it is primarily the need for nursing services, rather than for physician services, that justifies hospital admissions. The commenter suggested that use of the term "health care necessity" would emphasize this point.

Response: We believe the proposed provision makes it clear that services provided by the hospital, including nursing services, are subject to UR, and that introducing a new term not contained in section 1861(k) or the current or proposed regulations would not clarify this provision. Therefore, we did not adopt this comment.

Comment: One commenter opposed the adoption of less restrictive UR requirements, and suggested that this could increase unnecessary utilization of services. This commentor suggested we retain the current UR requirements.

Response: As explained in the preamble to our January 4, 1983 NPRM, we believe it is essential to reduce the regulatory burdens on hospitals to the minimum level consistent with patient health and safety and statutory requirements. We have not seen any concrete evidence that our current UR requirements are more effective in preventing excessive utilization than our proposed special requirements. Moreover, we are enjoined (as discussed below) from implementing many of our current UR requirements. Therefore, we did not adopt this comment.

Comment: One commenter suggested that we make our UR requirements less restrictive by permitting a subgroup of the UR committee, or an individual designee, to conduct admission or continued stay reviews.

Response: While we support, in general, efforts to reduce unnecessary regulatory burdens on hospitals, we are unable to accept this comment. One of the benefits of UR is the educational aspect of committee review that comes from committee discussions of the proper use of expensive health care services, such as hospital services. To reduce decisions to a small component of the URC or an individual could markedly hamper this effort and could give the appearance of permitting one individual's judgment concerning care to override that of the attending physician. We believe that benefits of full committee participation far outweigh the benefits of a more streamlined approach.

Comment: One commenter suggested that we eliminate the current UR regulation and not replace it. This commenter believes this approach would enable hospitals to integrate UR activities into their overall quality assurance systems.

Response: Because of the specific requirements in section 1861(k), we do not believe it would be legally supportable to eliminate UR requirements entirely. However, hospitals would be free, under the UR requirements, to combine UR activities with other quality control measures.

Comment: Several commenters suggested that the reference to Professional Standards Review Organizations (PSROs) in proposed § 482.30 be changed to Peer Review Organizations (PROs), to reflect changes made by TEFRA.

Response: The statutory provisions for PROs have not yet been implemented. Therefore, we have decided to defer making this change until PROs are fully operational.

Additional comments were received regarding psychiatric hospitals. However, because such hospitals are excluded from the prospective payment system, related comments will not be discussed here.

Specifically, we are adding § 405.1042 to replace the current UR provisions for hospitals under prospective payment and avoid certain overly prescriptive and detailed specifics for those

hospitals. A more indepth discussion of the revisions can be found in the preamble to the proposal published on January 4, 1983. However, for purposes of these regulations, we are revising certain sections to reflect appropriate review under prospective payment. This review, in the way it is adjusted to the incentives created by prospective payment, should be similar to the approach taken with PSRO, PRO, and FI review under prospective payment. However, we must point out that the findings of such utilization review, particularly regarding approval of admissions and outlier care, do not substitute for FI review. These utilization review requirements are necessary to comply with current statutory requirements (e.g., 1861(k), 1814(a) (6) and (7)). As long as they are necessary, we believe it is important to conform them to the dominant incentives of the payment system, especially as it is inappropriate to continue existing requirements despite their diminished relevance and significance. We are concerned that the UR committee findings be appropriate and useful to the hospital. However, we cannot equate the activities of a hospital committee with FI review activities, and we will not be bound by UR committee approval of an admission or outlier case for purposes of Medicare payment under the prospective payment system.

Section 405.1042(c) requires that the UR plan provide for some type of admission review, either pre-admission, upon admission, or after admission. In appropriate admissions we will not recognize, for DRG rate payment purposes, any UR committee determinations regarding the appropriateness of individual days or services in non-outlier cases (§ 405.1042(d)).

As discussed above in the case of PSROs/PROs and FIs, days would be denied in day outliers and services would be denied in cost outliers. We will, in advance, determine the day and cost outlier points for each DRG. Hospital UR plans must include procedures under which the UR committee will automatically review day outliers (based on the hospital's reasonable estimate of the proper DRG) and will review the necessity for continued services in cases which the hospital believes will qualify for "extra" or outlier payment. Appropriate hospital personnel (e.g., those in the hospital finance office) should provide prompt notification to UR committees of cases which have reached or are about to reach the cost outlier point (§ 405.1042(e)), and retrospective review of such cases by UR committees will be permitted.

ii. We believe Medicare outlier payment should be denied or reduced if the quality of UR committee activities is inadequate. That should be reflected in the way in which the program adjusts its implementation of section 1866(d) of the Act, i.e., long stay cases. Current regulations (§405.163) prohibit payment after the 20th consecutive day if the Secretary determines the hospital has substantially failed to make timely utilization review decisions in long stay cases. However, under prospective payment, it is only when the 20th day occurs after the beginning of what the hospital reasonably estimates to be outlier status that we are interested in penalizing inadequate UR committee activities. We do not intend that the quality of UR committee long-stay review activities affect the DRG rate payment for an appropriate admission. Therefore, we are amending §405.163 to provide that, in non-outlier cases, the Secretary will not find that a UR committee failed to make timely utilization review based solely on its failure to conduct continued stay review after an appropriate admission. This retains the penalty for ineffective UR, when and if cases become day outliers and the day outlier point is at 20 days or beyond.

iii. Section 1814(a)(7) of the Act, which prohibits payment after a UR committee finding that further care is not necessary, will now be interpreted to include only those committee findings that relate to situations in which additional payment would be made on the basis of medical need and utilization, i.e., outliers. To accomplish this, we are revising §405.162. Similar changes will be included in PRO regulations.

Physician Certification and Recertification

a. Discussion

Section 1814(a)(3) of the Act requires that no Medicare payment be made where a physician has failed to certify and, as appropriate, recertify that care is needed. Under the statute, in hospitals that are not tuberculosis or psychiatric hospitals, the certification must be no later than the 20th day of an inpatient hospital stay. Implementing regulations at §405.1627 (1) set forth what certifications and recertifications should contain; (2) permit certifications and recertifications of the need for inpatient hospital care due to unavailability of covered needed care in a skilled nursing facility; (3) allow for UR committee continued stay review to substitute for recertifications; and (4) require certifications no later than the 12th day of hospitalization and the first recertification no later than the 18th day of hospitalization.

b. Changes to the Regulations

We are revising current § 405.1627(b) to reflect prospective payment changes. For hospitals under prospective payment, we are requiring certification at the beginning of what the hospital reasonably assumes to be an outlier (cost or day), or no later than 20 days into the stay, whichever is earlier. As is currently the case, we will accept delayed certifications and recertifications.

The content of the physician certification statement will remain substantially the same. However, we are amending § 405.1627(a) to require a showing as to the need for special or unusual services in cost outlier cases. The physician is still authorized to recertify the need for hospital care if other needed covered care in an SNF is unavailable.

We are making no substantive changes in § 405.1629, governing certification and recertification for inpatient psychiatric and tuberculosis hospital services, because we assume that these hospitals, for the most part, will be excluded from prospective payment. We are, however, making minor technical amendments to this section to conform its language and cross-references to related regulations. In addition, we are making similar minor technical amendments to § 405.1630, concerning certification and recertification requirements applicable when a beneficiary is not entitled to benefits at the time of admission.

4. Quality Review

Section 1866(a)(1)(F) of the Act, effective October 1, 1984, authorizes PROs to review the quality of care provided by a hospital. Specific guidelines and procedures for PRO quality review will be included in PRO regulations and contracts which will be developed at a later date.

IV. PAYMENT FOR NONPHYSICIAN SERVICES FURNISHED TO HOSPITAL INPATIENTS

A. Background

Prior to Pub. L. 98–21, nonphysician services provided to Medicare beneficiaries who are hospital inpatients have generally been billed by the hospitals under Part A of the Medicare program. However, under certain circumstances, payments have been made for nonphysician services which

are furnished by an outside supplier or another provider and which have been billed by the outside source as a Part B service even though furnished to a hospital inpatient. Thus, some nonphysician services may have been billed under Part A in one hospital and under Part B in another. The practice of billing under Part B for these services has been referred to in the legislative history as "unbundling" of Part A services.

Under the new law, effective October 1, 1983, "unbundling" will be prohibited; that is, all nonphysician services provided in an inpatient setting will be paid only as hospital services. This rule will apply to all participating hospitals as of that date, regardless of a hospital's fiscal period, or inclusion or exclusion from the prospective payment system.

Section 602(e) of Pub. L. 98–21 added a new paragraph (14) to section 1862(a) of the Act, which provides for certain exclusions from Medicare coverage. The new section 1862(a)(14) provides that payment may not be made under either Medicare Part A or Part B for any expenses incurred for items or services—

> (14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital.

Further, section 602(f)(1) of Pub. L. 98–21, in adding certain additional statutory requirements, in section 1866(a)(1) of the Act, to the basic commitments into which a hospital must enter in making a provider agreement to participate in Medicare (see section V., on provider agreements following this section), provided that a participating hospital must agree—

> . . . to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.

Although most of the provisions of Title VI of Pub. L. 98–21 are effective for cost reporting periods beginning on or after October 1, 1983, these provisions, in accordance with section 604(a)(2), take effect on October 1, 1983. We wish to make it clear that these requirements do not apply only to hospitals under the prospective payment system, or even to hospitals reimbursed under our regulations at Part 405, Subpart D, but to all hospitals participating in Medicare, including those reimbursed under alternative arrangements such as demonstrations or State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. There is, however, a statutory provision for a waiver of this requirement, which could defer, for a time, application of these provisions to a hospital meeting certain criteria. Section 602(k) of Pub. L. 98–21 provides that, if a hospital has been extensively allowing Part B billing of inpatient services since before October 1, 1982, and if immediate compliance with these requirements would threaten the stability of patient care, the Secretary may waive these requirements for any cost reporting period beginning before October 1, 1986. The criteria for and terms of such waivers are discussed in the section V.C., below.

B. Part A Billing

The basic unbundling provision, section 1862(a)(14), provides that Medicare payment will not be made under Parts A or B if non-physician services are furnished to a hospital inpatient by anyone other than the hospital (that is, the hospital would have to furnish the services directly or under "arrangements", as defined in section 1861(w)(1). The term "under arrangements" refers to a manner of arranging to have services (other than physicians' services to individual patient) furnished by a supplier or provider outside the hospital. Under such arrangements, payment to the hospital for those services discharges the beneficiary's liability to pay for the services. Thus, the supplying organization must accept its payment from the hospital. The amount charged by the supplying organization and paid by the hospital is a cost to the hospital. If the hospital is not being paid under the prospective payment system, those costs are includable in its cost report. If the hospital is being paid on a prospective rate basis for the particular inpatient services, the prospective payment would include full payment for services furnished under arrangements.

In order to be paid under this provision, a hospital must bill under Medicare Part A for any service that falls within the scope of "inpatient hospital services" (see 1861(b)). Section 1833(d) prohibits Part B payment for services that may be paid for under Part A. The Senate Finance Committee report states that section 1862(a)(14) is intended to have the effect that payment under the prospective payment system be "payment in full for all covered items and nonphysician services to hospital inpatients." It further notes that this is done by providing that "all nonphysician services provided to hospital inpatients would be paid only as inpatient hospital services under Part A * * *" (S. Rept. No. 98–23, 98th Cong., 1st Sess. 50 (1983)).

Because Section 1862(a)(14) requires that, to qualify for Medicare payment, all services, with limited exceptions, provided to hospital inpatients must be provided directly or arranged for by the hospital, those services become "inpatient hospital services" payable under Part A for patients with Part A eligibility. Section 1833(d) then in turn requires that those services, to the extent that payment can be made for them under Part A, not be paid for under Part B. Therefore, it is essential that we require all services within the definition of inpatient hospital services to be billed under Part A, except when the patient is not eligible for Part A benefits, or if Part A benefits are exhausted before the patient is admitted or enters outlier payment status. Our interim final regulations include this requirement at § 405.470(b)(6).

C. Definition of Nonphysician Services

Section 1862(a)(14) excludes from Medicare coverage all items, supplies, and services furnished to an inpatient, "other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph)" that are not directly furnished by the hospital or by others under arrangements. As a result, we must make clear for purposes of this section which services furnished to inpatients are "physicians' services" within the meaning of the Act.

The definition of physicians' services reimbursable on a reasonable charge basis has been a matter of great controversy since the beginning of the Medicare program. To resolve this issue, Congress added a new section 1887(a) for the Social Security Act (enacted September 3, 1982 under section 108 of Pub. L. 97–248, the Tax Equity and Fiscal Responsibility Act of 1982). This section requires the Secretary to establish criteria in regulations that distinguish between physicians' services that are professional medical services personally furnished to an individual patient by a physician, and which contribute to the diagnosis or treatment of that patient and physicians' services and those that are for the general benefit of patients, such as quality control activities, are furnished to the provider, and, as provider services, must be paid for on

the basis of provider costs. In so establishing section 108 of TEFRA, Congress confirmed our long-standing interpretation of the requirements of the Social Security Act.

On March 2, 1983, we published final rules (with a comment period) on payment for physician services furnished in providers (48 FR 8902), implementing section 108 of TEFRA. In those regulations, we established explicit distinctions between physician services to individual patients, which are reimbursable on a reasonable charge basis under Medicare Part B, and physician services to the provider, which are of general benefit to patients and are reimbursable only on a reasonable cost basis. These regulations apply to services furnished in hospitals, SNFs, and CORFs, and apply to outpatient services covered under Medicare Part B (and paid on a reasonable cost basis) as well as to Part A services.

Pub. L. 98–21 amended section 1887(a) only to provide that physician services to the provider may be paid for only on a reasonable cost basis or under prospective payments under section 1886(d). Therefore, a hospital under the prospective payment system will be paid in full for physicians' services to the hospital related to care of Medicare inpatients as part of its prospective payments, and will be paid on a reasonable cost basis for such services related to care of Medicare outpatients. This amendment also clearly implies that, for purposes of implementing prospective payment, criteria for identifying physicians' services to inpatients payable on a reasonable charge should be consistent with criteria implementing section 1887(a).

Under the March 2, 1983 rules, § 405.550(b) of our regulations provides that physicians' services are medical services to individual patients and payable on a Part B charge basis if—

- The services are personally furnished to an individual patient by a physician;
- The services contribute directly to the diagnosis or treatment of an individual patient;
- The services ordinarily require performance by a physician; and
- If applicable, the services meet certain special rules that apply to services of certain physician specialties. (It was necessary to develop special distinguishing criteria for physicians' services furnished by anesthesiologists, radiologists, and pathologists (§§ 405.552, 405.554, and 405.556, respectively).)

We believe that we can best implement section 1862(a)(14) by identifying nonphysician services as those services furnished to hospital inpatients that do not meet the criteria of § 405.550(b), including the special criteria for anesthesiologists, radiologists, and pathologists. Therefore, we have added a new § 405.310(m) governing exclusions from coverage under section 1862(a). This new provision will ensure the greatest consistency and simplicity throughout the program. As a result, for the services a beneficiary receives as an inpatient of a hospital, we will be making separate and mutually exclusive payments for either physicians' services or hospital services. This new provision will minimize inconsistencies of coverage and payment between hospitals, and will greatly limit the opportunities for duplicate payments.

D. Services "Incident to" Physicians' Services

Another issue in implementing section 1862(a)(14) involves whether we should classify services furnished "incident to" physicians' services as physicians' or nonphysicians' services when they are furnished to a hospital inpatient for purposes of determining coverage under Medicare Part A or Part B. Section 1861(s) of the Act lists the medical and health services covered under Part B. Section 1861(s)(1) is "physicians' services" and section 1861(s)(2)(A) is "services and supplies . . . furnished as an incident to a physican's professional service." For coverage of the services furnished by nonphysicians as "incident to" services, Medicare requires an employer-employee relationship between the physician and the nonphysician (common law definition), that the physician be present when the service is furnished, and that the services be of the type commonly furnished in physicians' offices. Over the years, the "incident to" provision has been used as a basis for coverage of the services in hospitals of certain nurse anesthetists and various nonphysician therapists, such as physical and occupational therapists, employed by physicians. It is also the basis for coverage of items and supplies physicians furnish to patients, such as pacemakers, lenses, and artificial hip and knee joints.

However, many items and services paid for as incident to a physician's services have also been paid for under Part A as inpatient hospital services. For example, services of nurse anesthetist have been covered as inpatient hospital services when an anesthetist is employed by or contracts with a hospital. Thus, under current payment procedures, services and supplies furnished to inpatients in some hospitals are reimbursed under Part A while, in other hospitals, the same services and supplies are payable on a reasonable charge basis under Part B. The trend toward the provision of supplies and services by individuals and entities other than hospitals has contributed to higher program expenditures and a higher copayment burden on beneficiaries.

We believe that it is vital to the success of the prospective payment system that the services and supplies included in the payment be essentially the same in every hospital. Further, there is a strong statutory basis for discontinuing the use of "incident to" billing for services and supplies furnished to hospital inpatients. Section 1862(a)(14) states explicitly that only physicians' services are exempt from the requirement that all items and services furnished to hospital inpatient be provided directly or under arrangement. We could only exempt services incident to a physician's services if we determined that they were included within the definition of "physicians' services". The definition of such services in section 1861(q) of the Act, and our regulations at 42 CFR 405.550(b), both specify that physicians' services are performed by a physician. Thus, it is clear that services incident to a physician's services, which by definition are not performed by a physician, are subject to the exclusion from coverage under section 1862(a)(14). Therefore, we have included inpatient hospital services furnished incident to a physician's services, with one exception, in the new § 405.310(m), as services subject to that coverage exclusion.

The single, time-limited exception to this policy is the inpatient hospital services of anesthetists, such as certified registered nurse anesthetists, employed by physicians. During the prospective payment transition period, we will permit physicians who have customarily employed and billed on a reasonable charge basis for the services of anesthetists to continue this practice. The practice of physician-employer and anesthetist-employee is so wide spread, and the relationship of anesthesiologist to anesthetist is so unique, that we believe that it would be disruptive of medical practice and adverse to the quality if patient care to require all such contracts to be renegotiated in the limited time available before the implementation of the prospective payment system.

Therefore, we are providing, in § 405.553(b)(4), that, if a physician's practice was to employ anesthetists as

of the last day of a hospital's most recent 12-month or longer cost reporting period ending before September 30, 1983, then the physician may continue that practice through subsequent cost reporting periods beginning before October 1, 1986. However, if the physician chooses to continue this practice the hospital may not add the costs of the anesthetists' services to its base period costs for purposes of determining the hospital-specific portion of its transition payment rates.

E. Payment for Physician Radiology Services Furnished to Hospital Inpatients

The final rules published March 2, 1983 established a special test of reasonableness for charges for radiology services furnished in providers; that is, § 405.555(c)(2) provided that a carrier could not pay a physician, for any radiology service furnished in a provider, an amount exceeding 40 percent of the prevailing charge for a similar service furnished in a nonprovider setting. This limit ensured that payment for such services does not inappropriately include amounts reflecting the overhead costs associated with producing such services. However, that provision did not expressly apply to services furnished to provider inpatients outside the provider setting. (For example, since many hospitals do not own equipment for performing computed tomography (CT) scans, their patients may be transported to another hospital or a physician's office for such services.)

Under section 1862(a)(14) of the Act, we must pay the hospital for nonphysician services, such as overhead and operating costs, associated with furnishing radiology services to hospital inpatients. We may pay a physician (or other entity) only for the physician radiology services. We believe the best way to accomplish this is to apply the test we developed for services furnished in providers, thus ensuring consistent payment for all physician radiology services furnished to hospital inpatients. The nonphysician services associated with furnishing such radiology services will be paid for through the hospital since they must be furnished either directly or under arrangements. Therefore, we are amending § 405.555(c)(2) to ensure that the reasonable charge for any physician radiology service furnished to a hospital inpatient, regardless of the site at which the service is furnished, does not exceed 40 percent of the prevailing charge in a nonprovider setting.

F. Payment for Physicians' Services Furnished Through Independent Laboratories

Independent laboratories may furnish a variety of services to hospitals and their inpatients. Historically, these services have sometimes been paid for under Medicare Part B, in accordance with section 1861(s)(3), and have sometimes been furnished under arrangements and covered under Medicare Part A. These practices have not taken into consideration whether the service furnished through the independent laboratory included any services that qualified as physicians' service under section 1861(s)(1). In implementing section 1862(a)(14), however, we must distinguish between independent laboratory services which are nonphysician services for purposes of this provision, and which therefore must be furnished under arrangements, and any independent, laboratory services which qualify as physicians' services reimbursable on a reasonable charge basis under Part B.

In the March 2, 1983, regulations on payment for physicians' services furnished in providers, we established criteria for identifying physician laboratory services that are reimbursable on a reasonable charge basis. We believe that these criteria afford the most appropriate and consistent basis for distinguishing physicians' services reimbursable on a reasonable charge basis furnished by independent laboratories. These regulations, at 42 CFR 405.556, provide that physician laboratory services, to be reimbursable on a reasonable charge basis, must meet the requirements of § 405.550(b) (see discussion in paragraph V.C. of this preamble), and are—

- Anatomical pathology services;
- Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient; or
- Consultative pathology services that—
- Are requested by the patient's attending physician;
- Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;
- Result in a written narrative report included in the patient's medical record; and
- Require the exercise of medical judgment by the consultant physician.

In order to ensure that these criteria are applied to independent laboratory services furnished to hospital inpatients, we are amending § 405.556 in these interim rules by adding a paragraph explaining this application.

V. HOSPITAL PROVIDER AGREEMENTS

A. Background

Part 489 of Title 42 of the Code of Federal Regulations implements section 1866 of the Act, which specifies the terms of provider agreements and the providers that may enter into such agreements. Provider agreements are the basic legal instrument by which a provider enters into participation in the Medicare program. In these agreements providers agree to comply with the requirements of the Act, Title XVIII and related programs. If we find that a provider has not complied with those requirements and the implementing regulations, we may terminate the provider agreement, and thus terminate the provider's participation in the Medicare program.

Section 602(f) of Pub. L. 98-21 added three new paragraphs to section 1866(a)(1) of the Act. All three of these paragraphs refer explicitly to hospitals, rather than providers in general. They provide, in addition to the other requirements of section 1866, that in order to participate in Medicare and receive Medicare payment, a hospital must file an agreement with the Secretary—

(F) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (c) or (d) of section 1886, to maintain an agreement with a utilization and quality control peer review organization (if there is such an organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located) under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall be not less than an amount which reflects the rates per review

established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation)] of such reviews.

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), and

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital.

In addition to these new provisions, section 1866 was amended to conform generally to the prospective payment system established by Pub. L. 98–21. As a result, we must also make conforming changes in our regulations at Part 489.

B. Changes Affecting Basic Provider Agreement Commitments

In these interim regulations, we are amending Part 489 to eliminate inappropriately restrictive references to reasonable cost reimbursement (see § 489.3), and are amending § 489.20 (dealing with the basic commitments providers must make in their agreements) to add specific reference to the new commitments hospitals must make under sections 1866(a)(1) (F), (G) and (H).

Further, we are adding new language to § 489.21 (Specific limitations on charges) to reflect the requirements of the prospective payment system in general. This will take the form of a new paragraph (e), referring to inpatient hospital services paid for under the prospective payment system, and a new paragraph (f), referring to nonphysician services furnished to hospital inpatients. The new § 489.21(e) specifies that a hospital may not charge a beneficiary for inpatient hospital services for which the beneficiary would be entitled to have prospective payment made but for a denial or reduction in payments as a result of admissions or quality review. (See § 405.47 of this chapter or section 1886(f) of the Act.)

A new § 489.20(d) specifies that all Medicare covered services furnished to hospital inpatients, other than physician services reimbursable on a reasonable charge basis under § 405.550(b), must be furnished by the hospital or by others under arrangements made with them by the hospital. A new § 489.21(f) specifies that the hospital may not charge or permit others to charge for these services.

C. Waiver of Requirements of Section 1866(a)(1)(H)

Section 602(k) of Pub. L. 98–21 temporarily authorizes waiver, in certain circumstances, of the requirement that nonphysician inpatient hospital services be furnished either directly or under arrangements. Section 602(k) reads as follows:

(k) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physician services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

Since we are implementing section 1866(a)(1)(H) through amendments to our regulations governing provider agreements, we are also implementing this waiver authority through regulations in Part 489. This also ensures applicability of these requirements and waivers to all hospitals participating in Medicare, including not only hospitals paid under the prospective payment system, but those paid under reasonable cost reimbursement (regulations at 42 CFR Part 405, Subpart D), demonstrations, or the new regulations (published elsewhere in this issue of the **Federal Register** in 42 CFR Part 403 on State cost control systems implementing section 1886(c) of the Act.

We are establishing in these final rules a new § 489.23 that sets forth criteria for a waiver under section 602(k), specifies how a hospital must apply, and gives the terms that a hospital and its suppliers must meet under a waiver agreement. Essentially, to qualify for a waiver, a hospital must have allowed extensive billing under Part B for services furnished to inpatients before October 1, 1982, and must demonstrate that certain criteria we have established to determine whether this practice was so extensive that the hospital's immediate compliance with section 1862(a)(14) is impossible and that a sudden change in attempting to so comply would threaten the stability of patient care.

The first criterion is that a hospital must show that the outside suppliers' reasonable charges for nonphysician services in the hospital's base period must have been at least 125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital, exclusive of the costs for operating room, recovery room, labor and delivery room, and drugs and medical supplies charged to patients. Second, the hospital must show that at least three ancillary services furnished for its inpatients have been provided by outside suppliers and billed directly under Medicare Part B.

In developing these criteria, we relied on the clear intent expressed in the Senate Finance Committee Report (S. Rept. No. 98–23, 98th Congress, 1st Session, 50 (1983)) and the House Committee on Ways and Means Report (H. Rept. No. 98–25, 98th Congress, 1st Session, 138 (1983)). Congress intended that the waiver of the requirements of sections 1862(a)(14) and 1866(a)(1)(F) be granted in relatively few cases, that the administrative burden be limited, and yet that flexibility be provided for hospitals that currently do permit extensive Part B billing for inpatient services furnished to their inpatients.

We believe the 125 percent criterion is a reasonable measure of whether a significant proportion of services have been billed under Part B. By excluding from the comparison those ancillary services that generally are not reimbursable under Part B for hospital inpatients, the criterion recognizes that certain ancillary services must be furnished by the hospital and, at the same time, assures that the Part B billings are extensive for those services that can be billed by an outside supplier. The second criterion is based on the expectation expressed in the House Report that a change in billing arrangements for one or two services would not create hardship (H. Rept. 98–25, page 138).

The regulations also require that a hospital must show that its suppliers have agreed to certain conditions. First, the suppliers must agree to bill only for services for which payment may be made under Part B. This condition has the effect of limiting the waiver only to services that are covered under Part B and of protecting the beneficiary from being billed for services, such as drugs,

which would be covered under Part A if furnished by the hospital but cannot be covered under Part B when billed by an outside supplier.

Other requirements are necessary to enable us to make the required reduction in the hospital's prospective payment amounts to reflect Part B billings. Under section 602(K), we must reduce Medicare Part A payments to a hospital for the amount of Part B billings for nonphysician services furnished to the hospital's inpatients. To implement this requirement, we are requiring a hospital to show that its suppliers have agreed to the following practices:

- To bill the program directly (even if assignment is not taken) for services furnished to Medicare beneficiaries;
- To submit a bill within 30 days of a beneficiary's discharge;
- To specify on the bill that the services were furnished to an inpatient of a particular hospital; and
- To identify the nonphysician services that were furnished and the charge for each service.

VI. CONFORMING CHANGES

A. Explanation

The preamble to this interim final rule discusses many amendments, additions, and changes to our regulations as published in 42 CFR Chapter IV. There are a number of other changes that must be made in the CFR to make it consistent with the prospective payment system and the statutory changes made by Pub. L. 98–21.

In order to make clear the actual changes we are making in HCFA regulations as codified in the CFR, we are providing the following discussion, including some brief explanations of additions, deletions, and amendments to the regulations that are not discussed elsewhere in this document, but which are necessary and appropriate for the consistent implementation of Pub. L. 98–21. We are also including some technical corrections not directly related to the prospective payment system.

B. Introduction to Subpart D—§ 405.401

Because we have decided to incorporate the main prospective payment regulations in Subpart D, it is necessary to revise § 405.401, which serves as a general introduction to the entire Subpart. In addition, we are amending the table of contents of Subpart D by adding center headings designed to ease finding of the applicable sections of the regulations.

As revised, § 405.401 summarizes the applicability, structure, and scope of the provisions of Subpart D. In this section, we point out which providers and which cost will be reimbursed on a reasonable cost basis, and which will be paid on a prospective basis. We also point out special rules applying to ESRD facilities, teaching hospitals, and the costs of physician services to hospitals.

C. Methods of Apportionment Under Title XVIII—§ 405.404

The apportionment regulations set forth in § 405.404 are either obsolete or repetitive of regulations in §§ 405.452 (Cost related to patient care) and 405.453 (Adequate cost data and cost finding). Therefore, we are deleting this section.

D. Cost of Educational Activities—§ 405.421

Under section 1886(a)(4) of the Social Security Act, costs of approved educational activities will continue to be reimbursed on a reasonable cost basis. We have defined approved educational activities as those meeting the criteria of and within the scope of 42 CFR 405.421, Cost of Educational Activities. However, § 405.421(d) distinguishes only orientation and on-the-job training as not being within the scope of this regulation. Prior to the prospective payment system, this distinction was not significant, since training costs not within the scope of § 405.421, as well as costs of approved educational activities, were reimbursed on a reasonable cost basis.

This is no longer true for hospitals paid under the prospective payment system, since any training costs incurred by a hospital which are within the scope of § 405.421 will continue to be reimbursed on a reasonable cost basis, while costs not within the scope of the regulation will be considered part of inpatient operating costs to be included in the prospective payment rates. As the regulation now stands, costs of many types of training activities, which we do not consider within the scope of the regulation, will nonetheless qualify for separate reasonable cost reimbursement in addition to the prospective payments.

Therefore, it is important that we clearly differentiate between approved educational activities in which a hospital may be engaged and other training costs a hospital may incur. Approved educational activities are already adequately addressed. These activities are defined in § 405.421(b), while § 405.421(e) (and § 405.116(f)) list recognized approved medical and paramedical programs. Further, § 405.421(f) recognizes there may be additional approved training programs in which a provider is engaged.

On the other hand, other training activities are not adequately addressed in the regulations at §§ 405.421(d) and 405.451. To better define these activities, we are listing common examples of such training, currently listed in the Provider Reimbursement Manual section 416 (i.e., costs of a medical library, refresher and post-graduate programs, part-time education, educational workshops and training in use of medical appliances), in the regulations in § 405.421(d).

E. Grants, Gifts, and Income From Endowments—§ 405.423

Medicare policy concerning the treatment of grants and gifts has been in a state of transition for some time. As a general rule, grants and gifts that have been restricted by the donor to pay for a specific operating cost (or group of costs) have been used to reduce that cost. However, a number of exceptions to the general rule on the treatment of restricted contributions have been administratively established and implemented over time. The exceptions (which represent a liberalization of the rule) have resulted from situations where strict application of the general rule would not yield an equitable or desirable effect. These exceptions have included:

- Seed money grants;
- Deficit financing grants;
- Grants for primary care education programs;
- Contributions which benefit only non-Medicare patients; and
- Capital assets purchased with donated funds.

Except for grants for primary care education programs, the exceptions are not contained in the regulations, although they are being applied by the Medicare intermediaries.

The Omnibus Reconciliation Act of 1980 (Pub. L. 96–499) contained a provision dealing specifically with hospital philanthropy. Section 901 set out the same general rule pertaining to those contributions which shall not be offset as our regulations contain. In addition, the section reaffirmed the Secretary's authority not to offset those types of donor-restricted grants and gifts which the Secretary finds, in the best interests of needed health care, should be encouraged.

The intent behind the general rule pertaining to restricted contributions is to prevent providers from receiving double payment for a given cost—once from the contribution and once from Medicare—and to permit the Medicare program to derive the same benefit from the contribution as do others. We believe the general rule no longer has a significant impact on Medicare program outlays.

Hospitals are the largest beneficiary of restricted grants and contributions. Under the prospective payment system, the treatment of the grants and contributions for purposes of determining reasonable cost will not affect Medicare reimbursement for inpatient operating services.

Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating § 405.423. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

F. Compensation of Owners—§ 405.426

Existing regulations at § 405.426(d) state payment requirements that do not need to be incorporated in such regulations. Paragraph (d)(1) includes requirements concerning sole proprietorships that are implicit in other regulations at § 405.426(c)(2). Paragraph (d)(2) sets forth special rules on the compensation paid corporate "owners".

However, our program instructions in section 2305 of the Provider Reimbursement Manual (HCFA Pub. 15–1) provide rules applicable to liquidation of short-term liabilities that are sufficient to safeguard against abuse in this area. Therefore, we are deleting paragraph (d) from § 405.426.

G. Allowance in Lieu of Specific Recognition of Other Costs—§ 405.428

The provisions of this regulation have not been applicable to cost reporting periods beginning after June 30, 1969. It has long been obsolete, and we are therefore repealing it.

H. Return on Equity Capital—§ 405.429

Currently, we allow proprietary providers (as described in § 405.429(a)(2)) a reasonable return on equity capital invested and used in the provision of patient care. For these providers, we allow the amount of such a return as an amount in addition to the reasonable cost of covered services. This return on equity capital is being treated as a capital-related cost for the rate of increase ceiling (§ 405.463), and the prospective payment system.

Under regulations at § 405.429, we have, since 1966, determined the amount of the allowable return on equity "by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program". (§ 405.429(a)(1))

However, section 1886(g)(2) of the Act, added to title XVIII by Pub. L. 98–21, enacted April 20, 1983, provides that the amount of allowable return on equity capital related to inpatient hospital services shall "be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund." This provision is effective for cost reporting periods beginning on or after the date of enactment, that is, April 20, 1983.

We issued appropriate instructions revising chapter 12 of the Provider Reimbursement Manual (HCFA Pub. 15–1, Transmittal 292) in July, 1983. In addition, we are making conforming changes to our regulations at § 405.429(a)(1), in order to make clear that the rate of return on equity capital related to inpatient hospital services, as calculated for cost reporting periods beginning before April 20, 1983, is calculated in an identical manner, but set at a reduced level, for cost reporting periods beginning on or after April 20, 1983. No other regulatory changes are necessary to implement section 1886(g)(2) of the Act.

I. Inpatient Routine Nursing Salary Differential—§ 405.430

Section 103 of TEFRA eliminated this differential effective with services furnished on or after October 1, 1982. As a result, § 405.430 does not affect cost reporting periods ending on or after September 30, 1983. Therefore, we are eliminating this section effective October 1, 1983.

J. Physical and Other Therapy Services Furnished Under Arrangements—§ 405.432

Section 1861(v)(5) of the Act specifies that the reasonable cost of therapy services furnished under arrangements shall not exceed the amount that would be payable on a salary-related basis. The statutory provision is intended to control program expenditures and to prevent abuse. This abuse generally occurs by therapists contracted by other providers who have little or no financial incentive to control therapy costs. Since the costs of providing therapy services under arrangement are operating costs, the salary equivalency guidelines will not be applicable to inpatient hospital services covered under the prospective payment system. With respect to hospitals that are excluded from the prospective payment system, we believe that the rate of increase limitation under § 405.463 establishes a definite incentive to provide services in a prudent and cost-conscious manner and that the guidelines are unnecessary to assure that the requirement of Section 1861 (v)(5) is met with respect to inpatient hospital services. Therefore, effective with cost reporting periods beginning on or after October 1, 1983, inpatient hospital services will be excepted, under a new provision at § 405.432(f)(4), from the guidelines if the costs of the therapy services furnished under arrangements are subject to the provisions of §§ 405.463 or 405.470. The guidelines will continue to apply to services furnished to outpatients and to patients of a hospital-based SNF or hospital-based HHA, as well as for other providers reimbursed on a reasonable cost basis.

K. Swing-Bed Hospitals—§§ 405.434 and 405.452

On July 20, 1982, we published interim final regulations (with a comment period), implementing section 904, the "swing-bed" provision, of Pub. L. 96–499 (47 FR 31518).

This provision allowed certain small rural hospitals to use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries, and intermediate care facility (ICF) services to Medicaid beneficiaries. These hospitals are reimbursed for SNF and ICF services at rates appropriate to those services, which are generally lower than hospital rates. Special Medicare reimbursement rules for swing-bed hospitals were established at § 405.434, and special provisions for determining the appropriate cost of hospital and SNF services for purposes of Medicare reimbursement were added to § 405.452, Determination of cost of services to beneficiaries.

Those regulations governing Medicare reimbursement for swing-bed hospital services were based on reasonable cost reimbursement principles. However, under the prospective payment system, swing-bed hospitals are not excluded from prospective payment for the inpatient hospital services they furnish, and therefore we must change our method for paying swing-bed hospitals for inpatient hospital services. Since the prospective payment system applies only to payment for inpatient hospital services, the swing-bed regulations on

Medicare reimbursement for SNF-type routine and SNF-type ancillary services furnished in a swing-bed hospital will not change. That is, routine SNF-type services will continue to be reimbursed based on the prior calendar year Statewide Medicaid rate, and ancillary services furnished to swing-bed patients will continue to be reimbursed on a cost basis.

Under the present system, routine service costs applicable to swing-bed patients are subtracted (that is, carved-out) from total inpatient general routine service costs before computing the cost of furnishing routine services to hospital inpatients. The carve-out calculation is not appropriate under the prospective payment system because Medicare reimbursement for inpatient hospital services will not be based on cost. Swing-bed hospitals subject to the prospective payment system will be paid like any other hospital and the carve-out provision will not be applied.

Therefore, in these interim final regulations, we are amending existing swing-bed regulations as follows:

- § 405.434(c)(3) is revised to provide that the cost of swing-bed ancillary services will be determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital which are not inpatient services.
- The provisions of § 405.452(b)(3) (now located at § 405.452(b)(2)) are being revised to stipulate that the carve-out method for computing general routine inpatient hospital service costs does not apply to swing-bed hospitals that are subject to prospective payment.

L. Costs of Services to Beneficiaries—§ 405.452

Most of the provisions of § 405.452 have become obsolete. We are deleting those provisions and reorganizing the rest of the regulation.

M. Private Room Cost Differential—§ 405.452

We are amending the Medicare regulations on cost apportionment (42 CFR 405.452) to revise the methodology for computing reimbursement for inpatient general routine service costs. The regulations now provide that for cost reporting periods beginning October 1, 1982, or later, that in computing reimbursement for inpatient routine services, the difference in costs between private and semiprivate accommodations will be reimbursed only when private rooms are furnished to Medicare beneficiaries for medically necessary reasons. For hospitals subject to the prospective payment system, it will no longer be necessary to determine the higher costs of private rooms since the same amount per discharge will be paid regardless of whether private or semiprivate accommodations are provided. (Hospitals will, however, continue collecting the private room charge differential when private rooms are requested and are not medically necessary.)

N. Cost Data and Cost Finding—§ 405.453

Section 405.453(g) sets forth rules on outstanding current financing payments. All such cases involving current financing are now referred to either the General Accounting Office or to the Department of Justice for collection. Removal of this provision for future cost reporting periods will not affect the status of existing overpayment cases.

O. Lower of Cost or Charges—§ 405.455

We are revising the regulations at 42 CFR 405.455 to provide that the lower of cost or charges (LCC) provision will not apply to the determination of payment for Part A Medicare inpatient hospital services under either the rate of increase or the prospective payment system. With respect to the rate of increase provision, section 1886(b) of the statute, enacted by section 101 of TEFRA effective for cost reporting periods beginning on or after October 1, 1982, provides that the rate of increase ceiling provisions are to be applied in determining payment for inpatient operating costs notwithstanding section 1814(b) which is the LCC provision. With respect to hospitals subject to the prospective payment system, payment for inpatient operating costs is to be made on the basis of a fixed amount per discharge rather than on the basis of the lower of reasonable costs or charges.

We are discontinuing application of the lesser of cost or charges rule with respect to all Part A Medicare inpatient hospital services, effective October 1, 1982, rather than suspending application of the rule for only the operating costs of inpatient hospital services. "Operating costs of inpatient hospital services" are defined under the statute as "all routine operating costs, ancillary services operating costs and special care unit operating costs with respect to inpatient hospital services." Operating costs exclude capital-related costs, and costs allocated by a hospital to approved medical education programs, such as nursing school or approved intern and resident programs, on its Medicare cost report. In order to apply the lesser of cost or charges rule to capital-related costs, and costs of medical education programs, we would have to identify separate charges for these costs. However, hosptials generally do not establish separate charges for these types of costs. Therefore, we would be imposing a significant new recordkeeping burden on hospitals if we were to apply the lesser of cost or charges rule to these costs. For this reason, we have chosen to discontinue application of the lesser of cost or charges rule with respect to all Part A Medicare inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982.

We do not permit any unreimbursed costs from a prior cost reporting period to be recovered in any cost reporting period in which the allowable costs for that cost reporting period will exceed the cost limits established for inpatient hospital operating costs under 42 CFR 405.460. Therefore, we are also revising 42 CFR 405.455(d)(1) to state that we will not permit unreimbursed costs from a prior cost reporting period to be recovered in a current cost reporting period if the allowable costs of the current cost reporting period will exceed the rate of increase ceiling under 42 CFR 405.463.

P. Hospital Cost Limits–§ 405.460

Pub. L. 98–21 enacted section 1886(a)(1)(D) of the Act to provide that cost limits on hospital inpatient operating costs established under section 1886(a) would not apply to hospital cost reporting periods beginning on or after October 1, 1983. We had implemented section 1886(a) by amending our regulations at 42 CFR 405.460, which had been established to implement the cost limits authorized by section 1861(v)(1)(A) of the Act, as amended by section 223 of Pub. L. 92–603.

We are now further amending § 405.460 to provide that it does not apply to the operating costs of inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1983. With this one qualification, section 405.460 continues in effect unchanged, and we will continue to issue cost limits on SNF and HHA services under its authority. Further, we could at a future date, issue limits on hospitals' reimbursable costs, such as outpatient or capital-related costs, under the authority of § 405.460 and section 1861(v)(1) of the Act.

Q. Rate of Increase Limit—§ 405.463

In addition to establishing the prospective payment system, Title VI of Pub. L. 98–21 amended section 1886(b) of the Act which is implemented by regulations at § 405.463. Section 601(b) of Pub. L. 98–21 provided that:

- The rate of increase limit would continue indefinitely instead of being limited to 3 years duration;
- The target rate percentage must be based on a prospective estimate of the market basket increase;
- The rate of increase ceiling applies to all hospitals excluded from the prospective payment system under section 1886(d) of the Act; and
- The existing provisions on the FICA adjustment, which had not been implemented, were repealed, and a new paragraph 1886(b)(6) was added to the Act providing for adjustment of base period costs to account for FICA taxes incurred by a hospital that had not incurred such taxes in its base period.

In addition, section 601(a) of Pub. L. 98-21 amended the definition of inpatient operating costs for all hospitals under Medicare (see amended section 1886(a)(4) of the Act); therefore, changes are required in the rate of increase ceiling regulations.

As a result of these statutory amendments, we are amending § 405.463 in several ways:

- We are deleting all references to the inapplicability of the rate of increase limits to cost reporting periods beginning on or after October 1, 1985. Section 405.463 will now apply indefinitely.
- We are clarifying the costs subject to the ceiling, representing that for cost reporting periods beginning on or after October 1, 1983, only capital-related costs and the direct costs of approved medical education programs will be excluded from the ceiling. Hospitals must treat such costs consistently with treatment in their base period.
- We are providing that the target rate percentages by which target amounts will be determined will be published in a quarterly **Federal Register** notice. Target rate percentages will still be prorated for cost reporting periods that span portions of two calendar years. Further, we have made it explicit in the regulations that we will not retroactively adjust the prospectively set target rate percentages if the actual increase in the market basket differed from the estimate.

R. Physician Compensation Limits—§ 405.482

On March 2, 1983, we published in the **Federal Register** (48 FR 8902) final regulations on payment for physician services furnished in providers. (On May 31, 1983, we also published a notice (48 FR 24308) delaying the effective date of those rules from May 31, 1983, to October 1, 1983, coinciding with the effective date of these regulations.) Among other provisions, those regulations established reasonable compensation equivalent (RCE) limits on the amount of physician compensation allowable under Medicare for furnishing services to providers, implementing section 1887(a)(2) of the Act, enacted by section 108 of TEFRA.

Since March 2, 1983, Pub. L. 98-21 established the prospective payment system implemented in these regulations. Conforming changes made to section 1887(a)(1) by section 602(i) of Pub. L. 98-21 ensured that payment for physician services to included would be in prospective payments for inpatient hospital services. However, section 1887(a)(2) was not amended and applies only to cost reimbursement. As a result, RCE limits do not apply to the operating costs of inpatient hospital services paid for under the prospective payment system.

Therefore, we are amending § 405.482 to provide that the RCE limits do not apply to physician compensation related to inpatient hospital services paid for under the prospective payment system. As a result, we will apply these limits to inpatient operating costs, beginning October 1, 1983, only to hospital cost reporting periods, or portions thereof, that are not subject to the prospective payment system. However, even after a hospital comes under the prospective payment system, the RCE limits will apply to the hospital's outpatient costs.

S. Physician's Assumption of Provider Operating Costs—§ 405.550(e).

This provision was also added by the March 2, 1983 rules on payment for physician services furnished in providers. This paragraph had differing effective dates as set forth in § 405.550(e)(2) due to the impact of its provisions on lease arrangements, particularly the long-established relationships. Generally, these rules were to be effective June 30, 1983, but for such arrangements that predated the Medicare program, application of these rules was delayed until March 2, 1985. The rules made no provision for separate treatment of services based on the inpatient or outpatient status of provider patients.

As noted above, Pub. L. 98-21 established a new section 1862(a)(14), affecting services furnished to hospital inpatients, including those furnished by leased departments. In order to evaluate the relationships between the prospective payment legislation and the March 2, 1983 rules, the effective date of the entire package was delayed until October 1, 1983. The May 31 **Federal Register** notice (48 FR 24308) that announced this delay was not specific on the application of the rules to providers which would have qualified for the March 2, 1985 effective date.

The question now being addressed is whether the rules in § 405.550(e) should be applied with respect to services furnished to outpatients in those hospitals in which lease arrangements were established before July 1, 1966. We have decided that in view of the requirement of section 1862 (a)(14) and the exception to that requirement made available under section 602(k) of Pub. L. 98-21, we are deleting paragraph (e)(2). Thus, the March 2, 1985 effective date is not applicable to any hospital services. Hospitals that are granted the special waiver for the 3-year transition period under section 602(k) of Pub. L. 98-21 may continue to have such arrangements for outpatient services as well. No requests for exceptions from compliance with section 405.550(e) for services to outpatients will be considered.

In addition, we are making minor changes in the language of the other provisions of paragraph (e) to conform to the prospective payment system.

T. Payment for Anesthesia Services Furnished Directly by a Physician

Medicare policy has permitted payment for a physician's personally furnished anesthesiology services and anethetist services furnished "incident to" a physician's service in the same way, that is, on a reasonable charge basis under Part B, and in the same amount, that is, the reasonable charge for such service has been the same for an individual physician whether the service was personally furnished or furnished by an anesthetist in his or her employ. The final rules published on March 2, 1983, limited the number of concurrent services furnished by anesthetists that would qualify for reasonable payment. This limitation applied to services furnished "incident to" a physician's service. (We also, for the first time, provided for payment on a reasonable charge basis for a physician's medical direction of CRNAs not in his or her employ, but this change is not pertinent to this discussion.) Further, we provided a specific method for determining the reasonable charge for a physician's concurrent service.

We assumed that generally it would be understood that the method established in §§ 405.552 and 405.553 would apply when the carrier determined the reasonable charge for an anesthesiology service that was personally furnished by a physician. However, we did not explicitly provide this in our regulations. It is, of course, necessary to determine reasonable

charges for similar services in the same way. The carrier considers, in determining a reasonable charge, both the physician's customary charge for the service and the prevailing charge for the service in the locality. The prevailing charge is intended, among other things, to cover 75 percent of the customary charges made for similar services in the same locality during a specified period. It is only possible to do this if our carriers use a single system.

In the case of anesthesia, since physicians generally vary their charge for anesthesia services based on the duration of the surgery, the system we (and many Blue Shield Plans) use recognizes this factor. The majority of anesthesiologists bill charges that are derived from procedure-specific base units to which they add units for time intervals, e.g., 10, 12, or 15 minutes of elapsed time. They multiply the total units (e.g. base plus time) by a dollar amount to arrive at their charge for an individual service. Hence, our carriers base the customary and prevailing charges for anesthesiology services on the dollar amount multiplier because this is the sole constant factor used by most anesthesiologists nationwide. This is the applicable method for determining Medicare reasonable charges for personally furnished anesthesiology services, services of anesthetists that are "incident to" an anesthesiologist's services, and when applicable, for the "medical direction" an anesthesiologist furnishes to anesthetists who are not in his employ.

After publication of the March 2, 1983 final rules we received comments on how this would apply to physicians furnishing services directly, since there are some who do not set their charges this way. We have discussed those comments and our response to them in the notice on payment for physician services published elsewhere in this issue of the **Federal Register**. As a result, we are amending our regulations at §§ 405.552 and 405.553 to explicitly refer to services furnished by a physician without the assistance of an anesthetist. This conforms those provisions to our original intent, and ensures consistent payment for anesthesia services.

(Note: See section IV. D. of this preamble for other changes affecting payment for anesthesia services.)

U. Reimbursement of Health Maintenance Organizations (HMOs)—§ 405.2041(d)

We are amending paragraph (d) of § 405.2041 to delete inappropriate references to reasonable cost reimbursement. This regulation allows an HMO to elect to have providers of services that furnished covered services to the HMO's enrollees paid directly by Medicare. The HMOs will continue to have this election regarding hospitals paid under the prospective payment system.

V. Lifetime Reserve Days—§ 409.65(e)

Medicare provides coverage of up to 90 days of inpatient hospital services in a benefit period. Days of inpatient hospital services count toward this limit without regard to whether the beneficiary chooses to have Medicare pay for them. In addition, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital coverage to draw on after he or she uses the 90 days in a benefit period. Medicare payment is made for these additional days of hospital care after the 90 days of benefits have been exhausted, unless the beneficiary elects not to have such payment made (and thus save his or her reserve days for a later time). Under existing regulations at § 409.65, the beneficiary may, subject to certain restrictions, file an election not to use his or her lifetime reserve days for a particular hospital stay or part of a stay.

The option not to use lifetime reserve days for part of the nonoutlier portion of a stay, in conjunction with the prospective payment provisions, would give the beneficiary an advantage in the use of his or her lifetime reserve days not contemplated by the statute. Under § 405.470(b)(2) of the prospective payment regulations, the full prospective payment, exclusive of outliers, will be made for each stay during which the beneficiary receives at least one day of payable care. Thus, under the existing rules, a beneficiary would need to use only one lifetime reserve day for each hospital stay in order to have full prospective payment made on his or her behalf for the stay, not including outlier days, and could save the other reserve days to ensure full prospective payment for up to 59 additional hospital stays.

To avoid this unwarranted expansion of Medicare coverage, we are revising § 409.65(e) of the regulations to provide that if a beneficiary has exhausted his or her regular coverage in the benefit period, any election not to use lifetime reserve days under the prospective payment system must apply either to the entire stay, to all outlier days, or to all outlier days after a specified date. On the other hand, if a beneficiary has one or more days of regular coverage available upon entering the hospital, there will be no advantage in using lifetime reserve days, and he or she will be deemed not to use them, for days which are not outlier days. In this situation, the beneficiary may also elect not to use lifetime reserve days for outlier days but this election must apply either to all outlier days or to all outlier days after a specified date.

W. Technical Corrections

1. On April 5, 1983, we published final rules on coverage of services that are reimbursable under automobile medical, no-fault, or liability insurance, and services to ESRD beneficiaries covered under employer group health plans (48 FR 14802), adding new §§ 405.322 through 405.329 to Subpart C of our regulations. However, we did not at that time amend § 405.301, Scope of subpart, to reflect the new sections. Since we are amending Subpart C in these regulations, we are also correcting the oversight by adding appropriate language to § 405.301.

2. On March 2, 1983, we published in the **Federal Register** (48 FR 8902) final regulations on payment for physician services furnished in providers such as hospitals, skilled nursing facilities, and comprehensive outpatient rehabilitation facilities. Among other changes, those regulations established new §§ 405.550 to 405.556 to Subpart E, setting forth rules on payment on a reasonable charge basis for physicians' services to individual patients furnished in providers.

In these regulations, we are amending portions of those new sections of Subpart E, in order to implement the prospective payment system. However, since publication of those rules on March 2, 1983, we have also found the following technical errors in the regulations text published in that document, and are taking this opportunity to correct them. In § 405.550(d)(2), the word "applicable" was omitted before "conditions in §§ 405.552, 405.554, and 405.556". In § 405.554(b), a cross-reference to "§ 405.551(e)(2)" should have referred the reader to "§ 405.550(e)(2)". We erroneously stated in § 405.556(a) that certain rules would apply to "laboratory services furnished by a physician to an individual inpatient", when, in fact, it was clear from the preamble that we intended those rules to apply to all patients who received services in the provider, whether on an inpatient or outpatient basis. This document corrects that error by changing the term "inpatient" to "patient" in § 405.556(a).

VII. OTHER REQUIRED INFORMATION

A. Effective Dates

These interim final regulations are effective October 1, 1983.

In accordance with section 604(a)(1) of Pub. L. 98–21, these rules will generally apply to hospital cost reporting periods beginning on or after October 1, 1983. This is true of all the regulatory provisions, in particular §§ 405.470 through 405.477, that implement the prospective payment system for inpatient hospital services, and for other conforming changes except as specified.

The interim regulations implementing the "unbundling" provisions of Pub. L. 98–21, that is, sections 1862(a)(14) (added to Act by section 602(e)(3) of the 1983 amendments) and section 1866(a)(1)(H) (added to the Act by section 602(f)(1) of the 1983 amendments), are applied to items and services furnished on or after October 1, 1983, regardless of hospital cost reporting periods, in accordance with section 604(a)(2) of Pub. L. 98–21. This affects the amendments to §§ 405.301(m), 489.21, and 489.23.

In accordance with section 1886(g)(2) of the Act, enacted by section 601(e) of Pub. L. 98–21, the amendments to § 405.429 will be applied for cost reporting periods beginning on or after April 20, 1983.

The provisions of § 405.453(f)(3), relating to changes in cost reporting periods, implement section 604(a)(1) of Pub. L. 98–21 and are effective for cost reporting periods ending on or after the date of publication of these interim rules.

The amendments to § 405.455, referring to payment of the lesser of costs or charges, will be applied to all inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982.

Section 602(h)(2) of Pub. L. 98–21 amended section 1878(f)(1) of the Act regarding group appeals. These statutory amendments are self-implementing and were effective April 20, 1983. Therefore, our conforming amendments to regulations in §§ 405.1837, 405.1841, and 405.1877 cite that effective date and will be applied to such appeals as of April 20, 1983.

B. Waiver of 30-day Delay of Certain Effective Dates

As noted above, certain provisions of these interim rules will take effect without a 30-day delay in effective date. The amendments to § 405.429, Return on equity capital of proprietary providers; § 405.1837, Group Appeal; § 405.1841, Time, place, form, and content of request for Board hearing; and § 405.1877, Judicial review, will be applied as of April 20, 1983. The amendments to §405.455, Amount of payments where customary charges for services furnished are less than reasonable cost, will be applied to cost reporting periods beginning on or after October 1, 1982. The provisions of § 405.453(f)(3) relating to changes in cost reporting periods will be applied to cost reporting periods ending on or after the date of publication of these interim rules.

Generally, the Administrative Procedure Act requires us to provide a 30-day delay of a substantive rule (except for a rule that grants or recognizes an exemption or relieves a restriction), unless we find good cause and publish it with the rule (5 U.S.C. 553(d)). We have found good cause to waive this 30-delay for each of the regulation sections cited above.

Regarding § 405.429, section 1886(g)(2) of the Act specifies the applicable date. That statutory requirement is clear and self-implementing. Our amendment to § 405.429 merely conforms our published regulation to existing law and practice. A 30-day delay in implementing this amendment is unnecessary and would violate the statute.

The amendments to section 1878(f)(1) of the Act, requiring conforming changes to §§ 405.1837, 405.1841, and 405.1877, are also effective on the date of enactment of Pub. L. 98–21, April 20, 1983. Further, these changes are procedural, rather than substantive, and the provisions of the law are clear and self-implementing. Therefore a 30-day delay in effective date is unnecessary and impracticable.

The amendment to § 405.453, adding paragraph (3) regarding changes in cost reporting periods, is necessary to implement section 604(a)(1) of Pub. L. 98–21. It is primarily procedural, is necessary to ensure appropriate entry of hospitals into the prospective payment system, and is consistent with the intent of the law. Therefore, a 30-day delay in effective date is unnecessary and not in the public interest.

We have also found a delay in the effective date of § 405.455 to be unnecessary and impracticable. In implementing section 101 of TEFRA, which established a new section 1886 of the Act effective October 1, 1982, we provided, in accordance with the law, that the rate of increase limit implemented by § 405.463 would apply to inpatient hospital services without regard to the lesser of costs or charges provisions of section 1814(b) of the Act, as implemented in § 405.455 (§ 405.463(d)(1)). However, we did not make conforming changes to § 405.455 at the time we implemented § 405.463. As a result, § 405.455 has lacked substantial effect on payments for inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982. The amendments made in these interim rules are merely conforming changes that reflect existing law and practice.

C. Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us to publish general notice of proposed rulemaking in the **Federal Register**, and afford prior public comment on proposed rules. Such notice includes a statement of the time, place, and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed, and the terms or substance of the proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when an agency finds good cause that such a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rules issued.

These interim final rules include many amendments to our regulations. Generally, these amendments are necessary for the timely implementation of the prospective payment system established by section 1886(d) of the Act. As such, affording a proposed rulemaking process is impracticable, not in the public interest, and would violate the provisions of Pub. L. 98–21. Section 604(c) of Pub. L. 98–21 requires us to publish in the **Federal Register**, no later than September 1, 1983, interim final rules and an interim final notice of prospective payment rates for purposes of implementing section 1886(d) effective October 1, 1983. (The statute also requires us to afford a period of public comment on the interim final rules and rates, and to affirm or modify them, after considerations of comments, by December 31, 1983.) Therefore, we find good cause to waive proposed rulemaking for those regulatory provisions that are necessary to implement section 1886(d).

Section 1886(d) is primarily implemented by the new regulation provisions in §§ 405.414, 405.470 through 405.477, the amendments to various regulations such as those on utilization review, provider appeals, and lifetime reserve days necessary to avoid direct conflict with the prospective payment system, and the notice of prospective payment rates for hospital cost reporting periods beginning in Federal fiscal year 1984, which is published as an addendum to these interim rules. However, we believe that proper implementation of Pub. L. 98–21 and the prospective payment system

necessitates amendments to other regulations, both to prevent perverse interactions between existing rules and rules implementing prospective payment, and to ensure that the objectives of the prospective payment system are realized. As a result, we are including in these interim final rules a number of amendments to existing regulations that do not directly implement section 1886(d). In each case, however, we believe there is adequate justification for including these amendments with the prospective payment regulations, waiving proposed rulemaking and issuing them in interim final form.

The amendments to §§ 405.310(m), 489.21, and 489.23 implement provisions of sections 602 (e), (f), and (k) of Pub. L. 98–21 that have a statutory effective date of October 1, 1983 under section 604(a)(2) of Pub. L. 98–21. These provisions prohibit the "unbundling" of inpatient hospital services, as discussed in section IV of this preamble, and provide for waiver of that prohibition in certain circumstances. In addition, as also discussed in section IV, we have determined that it is necessary to amend §§ 405.550(e), 405.552, 405.553, 405.555, and 405.556, relating to reasonable charge payments for certain specialist physicians' services furnished in providers, to ensure that these charges appropriately exclude payment for inpatient hospital services furnished by nonphysicians. Implementation of these amendments as of October 1, 1983 is necessary to ensure that payments for inpatient hospital services under the prospective payment system is consistent from hospital to hospital. Because of the statutory effective date and the effect of these provisions on the implementation of section 1886(d) of the Act, we find that affording prior public comment before issuing these regulations in interim form is impracticable and not in the public interest.

Similarly, the amendments to § 405.463, Ceiling on rate of hospital cost increases, implement amendments to sections 1886 (a) and (b) of the Act made by sections 601 (a) and (b) of Pub. L. 98–21. Under section 604(a)(1) of Pub. L. 98–21, these amendments are effective for items and services furnished in cost reporting periods beginning on or after October 1, 1983. Further, since hospitals and distinct part units excluded from the prospective payment system will generally be subject to the rate of increase limits implemented by § 405.463, we believe it is necessary to implement these amendments concurrently with the implementation of the prospective payment system. Therefore, we have found that proposed rulemaking procedures are impracticable and not in the public interest.

We are also amending § 405.421 to clarify the definition of allowable costs for medical education, because certain medical education costs are excluded from payment under the prospective payment system. This was not necessary before, since all the costs were reimbursed on the same reasonable cost basis. However, under the prospective payment system, failure to properly define those medical education costs, for which payment in addition to prospective payments is permitted, could result in unnecessary and inappropriate payments. We have found that prevention of this adverse effect requires rulemaking on an interim basis concurrently with the prospective payment rules. Therefore, we find proposed rulemaking impracticable and not in the public interest.

Several other amendments implement recent statutory changes. These include § 405.429, Return on equity capital; § 405.430, Inpatient routine nursing salary cost differential; § 405.1837, Group appeal; § 405.1841, Time, place, form, and content of request for Board hearing; and § 405.1877, Judicial review. Since these statutory changes are clear and self-implementing, the amendments to these regulations are not necessary to implement section 1886(d). However, in view of the large number of changes we are making in payment practices, and the inevitable confusion that will occur during the initial implementaton of the prospective payment system, we do not believe that it is necessary or in the public interest to delay amending regulations to afford public comment when we have already changed our practices to implement the statute. Therefore, we have found good cause to include these technical and procedural (as opposed to substantive) amendments in these interim rules.

For similar reasons, we have decided to eliminate certain provisions of our Subpart D regulations that are outdated and no longer applied. These include § 405.404 Methods of apportionment under Title IVIII; the provisions of § 405.426(d), Compensation of owners, related to sole proprietorships; § 405.428, Allowance in lieu of specific recognition of other costs; most of the provisions of § 405.452, Costs of services to beneficiaries; and the provisions of paragraph (g) of § 405.453, Cost data and cost finding, relating to outstanding current financing payments. Since formal elimination of these provisions will have no adverse impact, and will not in fact result in changes in our payment practices, we find proposed rulemaking unnecessary.

Finally, we are also amending certain provisions of the Subpart D regulations in order to eliminate certain specialized limits on the costs of inpatient hospital services. We believe that these limits are contrary to the objectives of the prospective payment system. The sections affected by these amendments include § 405.423, Grants, gifts, and income from endowments; § 405.432, Physical and other therapy services furnished under arrangements; § 405.455, Amount of payments where customary charges for services furnished are less than reasonable cost; and the provisions of § 405.452, Determination of cost of services to beneficiaries, related to the private room cost differential. For reasons discussed above, we are eliminating § 405.423 entirely. We are amending the other sections in more limited ways: Sections 405.432 and 405.452 are being amended to ensure that they do not apply to hospitals paid under the prospective payment system, and § 405.455 is being amended to provide that the lesser of cost or charges provision does not apply to the costs of inpatient hospital services. We believe that the incentives established by the prospective payment system and rate of increase limits will appropriately restrain the costs of such services without the necessity for such intrusive rules on specific costs. Further, these amendments relieve existing restrictions and will simplify and improve program administration. Therefore, we find that delay of these amendments to afford comment before they take effect is unnecessary and contrary to the public interest.

For the above reasons, we find good cause to waive notice and public procedure before implementation of these interim final rules.

D. Paperwork Reduction Act

Certain sections of these regulations contain information collection requirements that are subject to the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). As required by that act, HCFA requested Office of Management and Budget (OBM) approval of these requirements. Under 44 U.S.C. 3507(g), OBM granted approval for 90 days after the date of publication of the regulations (September 1, 1983) under the following control numbers:

Section	Control Number
§ 405.476(d)(2)	0938-0308
§ 405.1042(c)	0938-0305
§§ 405.1627 and 405.1629	0938-0306
§ 489.23(b)(2) and (c)	0938-0304
§ 405-476(b)	0938-0309

We will submit a request for continued approval of the information collection requirements to OMB and will publish a notice in the **Federal Register** before the expiration of the interim OMB approval date when the continued approval is obtained.

The reporting requirements on base-year adjustments described in § 405.474(b)(2)(ii) and in section V. A.1. of the addendum are approved by EOMB. The control number is 0938–0288. The form that collects this data is the HCFA–1008, "Transmittal of Supplementary Information for Determination of the Target Amount Under the Medicare Prospective Payment System".

E. Public Comments

We are providing an opportunity for comment on these interim final rules in accordance with requirements in section 604(c)(1) of Pub. L. 98–21. Although these rules generally will be effective on October 1, 1983, regardless of comments received by that date, we will consider all comments received by the date specified in the "Dates" section of this preamble in the development of the final rules, which is to be published by December 31, 1983. Because of the large number of comments we receive, we cannot acknowledge or respond to them individually.

VIII. IMPACT ANALYSES

A. Executive Order 12291 and the Regulatory Flexibility Act

Executive Order 12291 requires that a regulatory impact analysis be performed on any major rule. A "major rule" is defined as one which would:

- Result in annual effect on the national economy of $100 million or more;
- Result in a major increase in costs or prices for consumers, any industries, any government agencies, or any geographic regions; or
- Have significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or import markets.

The Regulatory Flexibility Act requires that a regulatory flexibility analysis be prepared when a notice of proposed rulemaking is utilized. For purposes of the Regulatory Flexibility Act, small entities include all nonprofit and most for-profit hospitals.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives which minimize unnecessary burden or otherwise assure that regulations are cost-effective.

We are treating these regulations as a major rule under Executive Order 12291. Although the statute requires that the prospective payment system be budget neutral in fiscal years 1984 and 1985, we anticipate that the changed incentives of the system will result in annual program savings exceeding $100 million in subsequent years. Accordingly, the Executive Order definition of a "major rule" is met. The major features of the prospective payment system are specified in the statute, and we do not have administrative discretion to develop alternatives to them. The statute does allow the Secretary some administrative discretion in the implementation of the prospective payment system, and we will examine these provisions in another part of this analysis.

Because of the extensive changes in our methods of paying for inpatient hospital services under this rule, we are providing the following discussion which, combined with the rest of this preamble, constitutes a preliminary regulatory impact analysis and a preliminary and voluntary regulatory flexibility analysis. We solicit comments and factual information that would enable us to describe and quantify in greater detail the effects of the rule in the final analyses.

B. Nature of the Problem of Increased Health Care and Hospital Costs

Numerous studies have highlighted the dynamic growth in health care spending in the United States, particularly the rapid increase in Medicare program hospital costs. These cost issues have been, for many years, a focal point of discussion and action on the part of all levels of government and various sections of the health care industry. Of concern to us is that these increasing Medicare expenditures constrain the ability of the Federal government to fund other needed programs.

Hospital care represents a significant portion of present and projected health care expenditures. The cost increases experienced by hospitals, and the Medicare program, appear to be caused by several factors. Primary among these is general inflation in the economy. Inflation contributes significantly to the rapid rise in hospital costs particularly with regards to employee salaries and hospital supplies and equipment. A second contributing factor is the absence of traditional supply and demand forces operating to curb excessive expenditures. As third-party payors of medical care, including Medicare, cover an increasing portion of consumer medical care costs, the normal restraints on utilization and price that in other sectors of the economy are provided, in part, by consumers' capacity to pay, have been weakened. Decreasing consumer financial risk when medical care decisions are made tends to increase consumer demand for medical care services; this further exacerbates excessive health care expenditures.

A third factor is Medicare's current cost reimbursement system, which by its very nature tends to aggravate this cost problem. The economic incentives of this system contribute to cost increases by rewarding hospitals and physicians who increase utilization and thus their allowable reimbursable costs. There is little incentive for hospitals and physicians to operate more efficiently as all allowable costs are fully reimbursed.

A fourth factor that contributes to cost increases is the growth and increasing age of the beneficiary population.

As the percentage of the aged rises in contrast to the general population, the intensity and the costs of services rise because of the increased prevalence of chronic conditions and the incidence of serious illness common to the elderly. This trend can be seen especially among persons aged 75 years and over, an ever-increasing portion of the beneficiary population.

The combined effect of these factors is the explosion of overall health care utilization and expenditures, and of particular interest to the Medicare program, its payments for hospital care provided to beneficiaries.

C. Prospective Payment System as the Best Response to Certain Problems Related to Medicare Hospital Rate of Increase

Prospective payment rates begin to address increased hospital utilization by providing hospitals with a fixed set of payment rates for each type of discharge. Prospective rates represent a set of prices with characteristics similar to the prices a hospital would face in a more conventional market. The hospital knows the amount it will be paid per discharge and that the payment rate will remain unchanged regardless of its own cost experience. Of importance to the Medicare program, is that a prospective payment system will tend to restructure

the current incentives that influence the use of hospital resources and, therefore, the amount of Medicare payments for inpatient hospital services. As a means of restraining hospital expenditure growth, prospective payment places hospitals at risk in terms of the management of their operations and the use of their resources. Thus, we believe that this system will begin to address some of the serious problems inherent in the present cost reimbursement payment methodology and, therefore, will allow us to better manage the Medicare program and preserve the integrity of the trust funds.

Under this rule, hospital payment will be related to the treatment provided to each patient. However, since patients have different diagnoses, require different treatments, are of different ages, and differ in other ways, it is important that the payment system explicitly adjust for these differences. The failure of any system to account for these differences would severely harm certain types of hospitals.

In recognition of these concerns, Congress has determined that these differences will be accommodated by the use of diagnosis related groups (DRG) as the basis of payment determinations. This patient classification system has been under development at Yale University since 1969 and has been used in New Jersey's hospital reimbursement system since 1979.

DRGs offer the following advantages that will allow us to make prospective payment in full to hospitals for services provided to Medicare beneficiaries:

- The category definitions cover virtually the entire patient population;
- The groupings have been extensively reviewed by physicians for clinical coherence throughout their development;
- The DRGs conform closely to the organization (by clinical specialty) of the delivery of inpatient care in the hospital;
- The DRGs group those inpatient cases together which are generally quite similar in use of resources; and
- The DRGs allow inpatient records to be easily classified by an efficient computer program using readily available discharge abstract data.

Congress concluded that, based on these considerations, the DRG prospective payment system is the best available response to the problems of increased hospital expenditures currently experienced by the Medicare program.

D. Economic Impacts

As noted above, this analysis constitutes a voluntary regulatory impact analysis and a voluntary regulatory flexibility analysis. This portion of the analysis will discuss our estimates of the various impacts that are likely to result from the prospective payment system. We will discuss the impact on hospitals and beneficiaries and also examine the effect of this system on Medicare program operations. Finally, we will discuss the impacts resulting from other provisions within this final rule.

- *Hospital Impact*—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20, 1983. During the three years of the transition period, payment rates to about 5500 hospitals will be a blend of hospital-specific amounts based on each hospital's cost experience, and Federal amounts based on the averaged experience of hospitals. (See section III. C. of the preamble.) The initial impact of the prospective payment system will be like the impact that would have occurred to affected hospitals under the TEFRA provisions, because the hospital-specific portion of the first year's rate will be set at 75 percent of the TEFRA target amount. However, this impact will gradually change during the transition period, as the hospital-specific portion of the payment rate will be set at an increasingly lower percentage of each fiscal year's TEFRA target amounts. To correspond to the budget neutrality provision of the law, this estimated impact assumes no change in hospitals' economic behavior in response to this system.

However, prospective payment systems will change the economic incentives that influence a hospital's decisions in the use of resource inputs for each case. The profit potential inherent in this system alone should encourage hospitals to begin changing their behavior to decrease their operating costs. We believe that individual hospitals with lower current year operating costs per case will probably do better under this system than hospitals that cannot reduce or control these costs.

We also anticipate minimal differential impacts between hospitals in the first year, compared to the impact under the TEFRA provisions. Since we are required to use a transition period payment formula that blends both hospital-specific cost experience and Federal rates, the differential impact resulting from bed size or other economic factors, should not be significant between hospitals. This difference in impacts could be more pronounced in the long-run relative to each hospital's ability to respond to the incentives of this payment system.

The following provisions in the legislation seek to further moderate the impact of the prospective payment system.

- *Three-year Transition Period*—The phase-in process will not only reduce the possibility of a hospital experiencing extreme losses or profits during the initial years of this payment system, but it will also offer a financial incentive for improved hospital productivity throughout this period.
- *Blending of National and Regional Prospective Payment Rates*—During the second and third years of the transition period, the Federal portion of the prospective payment rates will be determined by using a blend of regional standardized amounts for urban and rural areas in addition to the national standardized amounts. This blending recognizes that there are some regional variations that exist in the cost of providing hospital care.
- *Other Provisions*—Other considerations aimed at moderating any impact include the exclusion of certain costs, wage adjustments, additional payments for the indirect costs of approved graduate medical education programs and additional payments for unusually long stay or costly cases.

We believe that hospitals can also temper any impact they experience resulting from this payment system. Several examples of management strategies that could be used by a hospital include:

- Management control systems that allow managers to formulate and monitor various efforts at improving the performance of individual cost centers. These control systems would provide information about the cost influencing variables that impact on a hospital's performance;
- Improving medical data processing and billing routines. The task of accurately coding and processing medical records is important in any hospital setting. Under prospective payment, medical records will become crucial because they indicate the

diagnoses, procedures, and factors used in determining which DRGs should be assigned and, therefore, how much a hospital is paid; and

• Examining the present relation of hospital management and attending physicians to determine the appropriate extent of physician involvement in the management control process. This is necessary because of the direct authority attending physicians have over inputs per case, which are key components of any hospital's costs. Also, there is demonstrable variation in treatment patterns among physicians according to various physician characteristics, such as specialty, Board certification, and age, which must be considered in selecting management strategies.

In the implementation of this system, we exercised some discretion in designing the following provisions with potential impact on hospitals. Alternative, non-selected criteria are discussed elsewhere in this preamble. Our rationale for these decisions is discussed below:

• *Criteria for Excluded Hospitals*—In establishing these criteria, we determined that a restrictive definition for excluded hospitals was preferred. A precise definition reduces potential administrative problems with intermediary billing determinations and ensures that appropriate payment is made to each hospital.

• *Exceptions and Adjustments Criteria*—We have adhered to the statute concerning exceptions and adjustments in developing these criteria. We believe that this decision preserves the integrity of the prospective payment system by limiting the number of hospitals that might receive an exception or an adjustment. To allow for numerous exceptions and adjustments could alter the payment amounts to other prospective payment hospitals in a manner not intended by Congress in requiring a budget neutral position. This definition will also cause hospitals to focus on ways to reduce operating costs instead of seeking ways to gain exceptions or adjustments.

• *Criteria for Waiver of Nonphysician Services Requirement*—Effective October 1, 1983, all non-physician inpatient services must be furnished under Part A directly by the hospital or billed to the hospital by the outside supplier. The statute gives the Secretary authority to waive this requirement and permit continued Part B billing during the transition period where the services have been so extensively billed under Part B that immediate compliance would threaten the stability of patient care. We selected a stringent approach in implementing this provision to ensure that a limited number of hospitals will operate under this waiver prior to October 1, 1986. To grant waiver status to others would result in administrative difficulties and increased costs in facilitating the billing requirements of such an arrangement.

• *Establishing Prospective Payment Prices*—The law is very specific regarding how prices shall be determined for operating costs of inpatient hospital services. However, some technical discretion is required to develop many of the technical features of the payment system. In developing this system we believe that we are using the best methodology available.

• *"Incident To" Provision*—Section 602(e)(3) of Pub. L. 98–21 establishes a new section 1862(a)(14) of the Act and provides the statutory authority, we believe, to include services "incident to" physicians' services furnished to hospital patients as hospital services paid for from the Part A trust fund instead of as Part B physicians' services. We are exercising our discretion in this manner to ensure consistency in determining which services are to be paid as hospital services and which services can be billed separately under Part B.

We believe that our discretion in all of these cases will result in cost-effective outcomes and will preserve the integrity of the prospective payment system.

• *Operational Impact*—To implement the prospective payment system, intermediaries will be required to make some changes in their claims processing system, increase auditing activities, and train providers to submit appropriate forms. The intermediaries will be reimbursed in full for their costs. The estimated incremental administrative costs for implementing and operating the prospective payment plan are: $27.5 million in FY 1983, $17 million in FY 1984, and $3.8 million in FY 1985.

• *Beneficiary Impact*—We believe that Medicare beneficiaries will be affected by the prospective payment system in several ways. First, their financial liability will remain limited to the coinsurance and deductible payments mandated by Congress. However, some beneficiaries will be advantaged by our prohibiting the "unbundling" of Part A services (as discussed in section IV of the preamble). Their previous Part B coinsurance payments for these services would now be eliminated as these services are now considered inpatient hospital services subject to the prospective payment methodology.

Second, we anticipate that quality of care for beneficiaries will be maintained or improved. Quality of care is protected in a number of ways separate from this regulation, and results of several recent studies indicate that prospective payment programs operating to date have not compromised the quality of care provided in hospitals, even while such programs generally reduce the intensity of care provided to patients. In addition, insofar as prospective payment encourages specialization in certain services, we believe treatment may be improved for beneficiaries and other patients. And insofar as prospective payment acts to constrain cost increases, it will contribute to maintaining the affordability and accessibility of quality care.

We intend to monitor admission and physician practice patterns to ensure that beneficiaries continue to receive care that is reasonable and necessary and of good quality.

• *Impact of Other Provisions*

—Section 1886(c) of the Social Security Act sets forth the conditions and procedures under which Medicare payment will be made for hospital services under State reimbursement control systems. This provision immediately impacts hospitals in four States (New York, Massachusetts, Maryland and New Jersey). The impact of this provision is examined in the Impact Analysis section of the "Recognition of State Reimbursement Control Systems" final rule published separately in another **Federal Register** issue.

—Section 601(b) of Pub. L. 98–21 amends section 1886(b) of the Act. This amendment sets forth target rate percentages needed to limit the rate of increase on hospital inpatient operating costs and related updating factors for use in computing the hospital-specific portions of transition payment rates under the prospective payment system. The impact resulting from this provision is examined in the final notice for "Schedule of Target Rate Percentages" published elsewhere in this **Federal Register** issue.

—We have noted several conforming changes in section VI. of the preamble. These changes must be made to make our existing regulations consistent with the objectives of the prospective payment system and the statutory changes made by Pub. L. 98–21. We are also including some technical corrections that have no economic impact.

We believe that apart from the return on equity capital provision (§ 405.429), these changes do not result in significant

economic impacts. We estimate that the amendment to the return on equity capital provision will generate $100 million in savings in FY 1984 and $115 million in FY 1985. However, this impact results from the statute (section 1886(g)(2) of the Act) and not this regulation, which merely implements the statute.

E. Benefits

This change in our payment methods will result in numerous net benefits to society and to the Medicare program. In the near term, these benefits will probably not result in a significant impact on the economy. Due to our phasing-in of the payment system, the full extent of the anticipated benefits will be realized when the system is fully operational and hospitals have implemented cost-effective management strategies in response to the system.

Included among these benefits are:

- Restructuring the economic incentives facing the health care system to establish market like forces;
- Restraining hospital cost increases which will preserve the integrity of the Medicare trust funds and the financial status of other payors;
- Adopting an active role on behalf of Medicare beneficiaries, in determining payment made for inpatient services. This will establish the Federal government as a prudent buyer of services;
- Payment being based upon the type of discharge will identify, more accurately than the present system, the product being purchased on behalf of Medicare beneficiaries. This approach over time will have desirable effects regarding hospitals' decisions on which services to provide.
- A strong link between payment and diagnosis, along with the ability for hospitals to retain any amounts by which their prospective payment rates exceed their costs. This will invite more active medical participation in the financial and operating routines of hospitals; and,
- Providers being able to identify, in terms of revenue to the institution, what services they deliver well and what services they do not provide efficiently.

F. Conclusion

Taken together, these statutory and regulatory provisions and the flexibility these rules provide hospitals mean that these rules meet the objectives of E. O. 12291 and the Regulatory Flexibility Act, including:

- Minimization of significant economic impact on small entities, including use of timetables, adjustments for geographic and other differences, and use of performance rather than design standards; and
- Choosing alternatives involving the least net cost to society, taking into account the conditions of the hospital industry.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Part 409

Blood, Health insurance, Home health, Hospitals, Inpatients, Medicare, Nursing homes.

42 CFR Part 489

Clinics, Health care, Health facilities, Medicare, Provider Agreements, Rural health clinics, Termination procedures.

42 CFR Chapter IV is amended as set forth below:

A. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. Subpart A is amended as set forth below:

Subpart A—Hospital Insurance Benefits

a. The authority citation for Subpart A is revised to read as follows:

Authority: Secs. 1102, 1814, 1815, 1861, 1866(d), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395f, 1395g, 1395x, 1395cc(d), and 1395hh).

b. Section 405.162 is revised to read as follows:

§ 405.162 Prohibition against payment for inpatient hospital services furnished after utilization review finding that further services are not medically necessary.

(a) *Hospital system of utilization review.* If a finding has been made under a hospital system of utilization review (see §§ 405.1035 and 405.1042) that further inpatient hospital services are not medically necessary, payment may be made only for those inpatient hospital services furnished before the fourth day following the day on which the hospital received notice of the finding.

(b) *PSRO and PRO system of review.* If a Professional Standards Review Organization (PSRO) or a Utilization and Quality Control Peer Review Organization (PRO) has assumed review responsibility in accordance with the applicable provisions of § 405.472 and of Part 463 of this chapter for the inpatient hospital services furnished by or in the hospital, the payment limitation described in § 463.17(a) applies to the inpatient hospital services furnished to a beneficiary and shall be in lieu of the payment limitation in paragraph (a) of this section.

(c) If a hospital is paid for inpatient hospital services under the prospective payment system established by §§ 405.470 through 405.477, the payment limitation in paragraph (a) of this section applies only in cases otherwise eligible for outlier payment under § 405.475 if the utilization review committee determines that—

(i) Excess days of care furnished in the case of a length of stay outlier are not necessary to furnish services covered under Medicare Part A; or

(ii) Additional items and services furnished in the case of a high cost outlier are either not covered or not necessary to furnish services covered under Medicare Part A.

c. Section 405.163 is amended by redesignating the previously uncoded paragraph as paragraph (a), revising it, and adding a new paragraph (b). As revised the section reads as follows:

§ 405.163 Prohibition against payment for inpatient hospital services furnished after 20th consecutive day by a hospital which has failed to make timely utilization review.

(a) When HCFA has determined that a hospital has substantially failed to make timely utilization review in long stay cases and has imposed the limitation on days of services provided in section 1866(d), no payment may be made under this Subpart A for inpatient hospital insurance services furnished by such hospital to any individual after the 20th consecutive day on which such services have been furnished to him if the individual is admitted after the effective date of such determination.

(b) HCFA will not make a finding of failure to make timely utilization review, as described in paragraph (a) of this section, that would have the effect of altering prospective payment amounts determined under §§ 405.473, 405.474, and 405.476.

2. Subpart C is amended as set forth below:

Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

a. The authority citation for Subpart C is revised to read as follows:

Authority: Secs. 1102, 1815, 1833, 1842, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395g, 1395l, 1395u, 1395y, 1395cc, 1395gg, 1395hh, 1395pp), and 31 U.S.C. 3711.

b. Section 405.301 is revised to read as follows:

§ 405.301 Scope of subpart.

Sections 405.310 to 405.320 describe certain exclusions from coverage applicable to hospital insurance benefits (Part A of Title XVIII) and supplementary medical insurance benefits (Part B of Title XVIII). The exclusions in this subpart are applicable in addition to any other conditions and limitations in this Part 405 and in Title XVIII of the Act. Sections 405.322 to 405.325 relate to exclusion of services covered under automobile medical, no-fault, or liability insurance. Sections 405.326 to 405.329 relate to limitations on payment for services to ESRD beneficiaries who are covered under employer group health plans. Sections 405.330 to 405.332 relate to payments for expenses for certain items or services otherwise excluded from coverage. Sections 405.340 to 405.344 relate to limitation on payment for services furnished to employed aged and their spouses. Sections 405.350 to 405.359 relate to the adjustment or recovery of an incorrect payment, or a payment made under section 1814(e) of Part A of Title XVIII of the Act. Sections 405.370 to 405.373 relate to the suspension of payment to a provider of services or other supplier of services where there is evidence that such provider or supplier had been or may have been overpaid.

c. Section 405.310 is amended by reprinting the undesignated introductory material unchanged and adding a new paragraph (m) to read as follows:

§ 405.310 Types of expenses not covered.

Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services.

* * * * *

(m)(1) Except as provided under paragraph (m)(3) of this section, items, supplies and services furnished to hospital inpatients on or after October 1, 1983, that—

(i) Do not meet the criteria set forth in § 405.550(b) that describe services of physicians to provider patients that are reimbursable on a reasonable charge basis; and

(ii) Are not furnished by the hospital either directly or under arrangements as defined in § 409.3 of this chapter.

(2) Items, supplies, and services (other than physicians' services to individual patients) that are excluded if they are not furnished directly or under arrangements include, but are not limited to—

(i) Clinical laboratory services;

(ii) Pacemakers;

(iii) Artificial limbs, knees, and hips;

(iv) Intra-ocular lenses;

(v) Total parenteral nutrition; and

(vi) Services and supplies furnished incident to physicians' services (except for anesthetist services that continue to be billed for by a physician employer under § 405.553(b)(4)), as described in §405.231(b).

(3)(i) Except as provided in paragraph (m)(3)(ii) of this section, the items, supplies, and services described in paragraphs (m) (1) and (2) of this section—

(A) Are inpatient hospital services;

(B) May not be paid for under Medicare Part (B); and

(C) Must be billed by the hospital to its intermediary under Medicare Part A for the hospital to be paid for such services.

(ii) A hospital may seek payment under Medicare Part B for the items and services described in paragraphs (m) (1) and (2) of this section only if—

(A) No payment will be made for such items or services under Medicare Part A; and

(B) The beneficiary is entitled to have payment made for such services under Medicare Part B.

(4) HCFA may waive the requirements of paragraphs (m) (1), (2), and (3) of this section for any cost reporting period beginning before October 1, 1986, in accordance with § 489.23 of this chapter.

* * * * *

3. Subpart D is amended as set forth below:

a. The authority citation for Subpart D reads as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

b. The table of contents of Subpart D is revised by adding undesignated center headings, removing §§ 405.404, 405.423, 405.428, and 405.430, adding a new § 405.414, and adding new § 405.470 through 405.477 to read as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

c. Section 405.401 is revised to read as follows:

§ 405.401 Introduction.

(a) *Scope.*

(1) *General summary.* This subpart sets forth regulations governing Medicare payment for services furnished to beneficiaries by—

(i) Hospitals;

(ii) Skilled nursing facilities (SNFs);

(iii) Home health agencies (HHAs);

(iv) Comprehensive outpatient rehabilitation facilities (CORFs);

(v) End-stage renal disease (ESRD) facilities; and

(vi) Providers of outpatient physical therapy and speech pathology services (OPTs).

(2) *Applicability.* The principles of payment and the related policies described in this subpart apply to HCFA, to the fiscal intermediaries acting as payors of claims on HCFA's behalf, to the Provider Reimbursement Review Board, and to the hospitals, SNFs, HHAs, CORFs, ESRD facilities, and OPTs receiving payment under this subpart.

(b) *Reasonable cost reimbursement.* Except as provided under paragraphs (c) through (e) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services, if lower. Regulations implementing section 1861(v) are found generally in this subpart beginning at § 405.402.

(c) *Oupatient maintenance dialysis and related services.* Section 1881 of the Act authorizes special rules for the coverage of and payment for services furnished to ESRD patients. Sections 405.438 through 405.441 implement various provisions of section 1881. In particular, § 405.439 establishes a prospective payment method for outpatient maintenance dialysis services that applies both to hospital-based and independent ESRD facilities, and under which Medicare pays for both home and infacility dialysis services furnished on or after August 1, 1983.

(d) *Payment for inpatient hospital services.*

(1) For cost reporting periods beginning before October 1, 1983, the amount paid for inpatient hospital services is determined on a reasonable cost basis.

(2) Except as provided in paragraph (e) of this section, for cost reporting periods beginning on or after October 1, 1983 the following applies:

(i) Payment to short-term general hospitals (other than children's, psychiatric, and rehabilitation hospitals, and psychiatric and rehabilitation units, as described in § 405.471(c)) located in the 50 States and the District of Columbia for the operating costs of inpatient hospital services is determined prospectively on a per discharge basis under §§ 405.470 through 405.477. Payment to these hospitals for capital-related costs (as described in § 405.414) and direct medical education costs (as described in § 405.421, with the exception of those costs described in § 405.421(d)) is made on a reasonable cost basis.

(ii) Payment to children's, psychiatric, rehabilitation and long-term hospitals (as well as separate psychiatric and rehabilitation units (distinct parts) of short-term hospitals), which are excluded from the prospective payment system under § 405.471(e), and to hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 405.463.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this subpart, if the State system is approved by HCFA. Regulations implementing this alternative reimbursement authority are set forth at 42 CFR Part 403, Subpart C.

§ 405.404 [Removed]

d. Section 405.404 is removed.

e. A new § 405.414 is added to read as follows:

§ 405.414 Capital-related costs.

(a) *General rule.* Capital-related costs and allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 405.415, 405.417, and 405.418, adjusted by gains and losses realized from the disposal of depreciable assets under § 405.415(f)(2).

(2) Taxes on land or depreciable assets used for patient care.

(3) Leases and rentals, including license and royalty fees, for the use of depreciable assets, as described in paragraph (b) of this section.

(4) The costs of betterments and improvements as described in paragraph (c) of this section.

(5) The costs of minor equipment that are capitalized, rather than expensed, as described in paragraph (d) of this section.

(6) Insurance expense on depreciable assets, as described in paragraph (e) of this section.

(7) Interest expense as determined under § 405.419, subject to the qualifications of paragraph (f) of this section.

(8) For proprietary providers, return on equity capital, as determined under § 405.429.

(9) The capital-related costs of related organizations (as described in § 405.427), as determined in accordance with paragraph (g) of this section.

(b) *Leases and rentals.* (1) Subject to the qualifications of paragraphs (b)(2) and (4) of this section, leases and rentals, including licenses and royalty fees, are includable in capital-related costs if they relate to the use of assets that would be depreciable if the provider owned them outright. The terms "leases" and "rentals of assets"

signify that a provider has possession, use, and enjoyment of the assets.

(2) A provider must include incurred rental charges in its capital-related costs, as specified in a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, only if—

(i) The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented; and other provisions of the rental agreements;

(ii) Adequate alternate facilities or equipment which woud serve the purpose are not or were not available at lower cost; and

(iii) The leasing was based on economic and technical considerations.

(3) If the conditions of paragraph (b)(2) of this section are not met, the amount a provider may include in its capital-related costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount which the provider would have included in capital-related costs had the provider retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, and insurance costs.

(4) A lease that meets the following conditions is a virtual purchase:

(i) The rental charge exceeds rental charges of comparable facilities or equipment in the area.

(ii) The term of the lease is less than the useful life of the facilities or equipment.

(iii) The provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

(5)(i) If a lease is a virtual purchase under paragraph (b)(4) of this section, the rental charge is includable in capital-related costs only to the extent that it does not exceed the amount which the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. A provider may not include in its capital-related costs accelerated depreciation in this situation.

(ii) The difference between the amount of rent paid and the amount of rent allowed as capital-related cost is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(iii) If an asset is returned to the owner, instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(v) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(c) *Betterments and improvements.* (1) Betterments and improvement are changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the productivity of an asset significantly over its original productivity.

(2) A provider must capitalize and pro-rate the costs of betterments and improvements over the remaining estimated useful life of the asset, as modified by the betterment or improvement.

(d) *Minor equipment.* A provider must include in its capital-related costs the costs of minor equipment that are capitalized rather than charged off to expense if—

(1) The net book value of minor equipment at the time the provider enters the program is pro-rated over three years (that is, one-third of the net book value is written off each year), and new purchases are also pro-rated over a 3-year period; or

(2) The cost of minor equipment is prorated over their actual useful lives.

(e) *Insurance.* (1) A provider must include in its capital-related costs the costs of insurance on depreciable assets used for patient care or insurance that provides for the payment of capital-related costs during business interruption.

(2) If an insurance policy also provides protection for other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance, only that portion of the premium related to the replacement of depreciable assets or to pay capital-related costs in the case of business interruption insurance is includable in capital-related costs.

(f) *Interest expense.* (1) A provider must include in its capital-related costs interest expense, as described in § 405.419, if such expense is incurred in—

(i) Acquiring land and/or depreciable assets (either through purchase or lease) used for patient care; or

(ii) Refinancing existing debt, if the original purpose of the refinanced debt was to acquire land an/or depreciable assets used for patient care.

(2) If investment income offset is required under § 405.419(b)(2)(iii), only that portion of investment income that bears the same relationship to total investment income as the portion of capital-related interest expense bears to total interest expense is offset against capital-related costs.

(g) *Costs of supplying organizations.* (1) *Supplying organization related to the provider.*

(i) If the supplying organization is related to the provider within the meaning of § 405.427, except as provided in paragraph (g)(1)(ii) of this section, a provider's capital-related costs include the capital-related costs of the supplying organization.

(ii) If the costs of the services, facilities or supplies being furnished exceed the open market price, or if the provisions of § 405.427(d) apply, no part of the cost to the provider of the services, facilities, or supplies are considered capital-related costs, unless the services, facilities or supplies would otherwise be considered capital-related.

(2) *Supplying organizations not related to the provider.* If the supplying organization is not related to the provider within the meaning of § 405.427, no part of the charge to the provider may be considered a capital-related cost (unless the services, facilities or supplies are capital-related in nature) unless—

(i) The capital-related equipment is leased or rented by the provider;

(ii) The capital-related equipment is located on the provider's premises; and

(iii) The capital-related portion of the charge is separately specified in the charge to the provider.

(h) *Cost excluded from capital-related costs.* The following costs are not capital-related costs. To the extent that they are allowable, they must be included in determining each provider's operating costs:

(1) Costs incurred for the repair or maintenance of equipment or facilities.

(2) Amounts included in rentals or lease payments for repair or maintenance agreements.

(3) Interest expense incurred to borrow working capital (for operating expenses).

(4) General liability insurance or any other form of insurance to provide

protection other than for the replacement of depreciable assets or to pay capital-related costs in the case of business interruption.

(5) Taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(6) The costs of minor equipment that are charged off to expense rather than capitalized as described in paragraph (d) of this section.

f. Section 405.421 is amended by revising paragraph (d) to read as follows:

§ 405.421 Cost of educational activities.

* * * * *

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles—

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances; and

(6) Other activities which do not involve the actual operation or support (except through tuition or similar payments) of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

* * * * *

§ 405.423 [Removed]

g. Section 405.423 is removed.

§ 405.426 [Amended]

h. Section 405.426 is amended by removing paragraph (d).

§ 405.428 [Removed]

i. Section 405.428 is removed.

j. Section 405.429 is amended by revising paragraph (a) to read as follows:

§ 405.429 Return on equity capital of proprietary providers.

(a) *Principle.* (1) *Rate of return.*

(i) A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers.

(ii) Except as provided in paragraph (a)(1)(iii) of this section, the amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(iii) For cost reporting periods beginning on or after April 20, 1983, the amount allowable in determining the return related to inpatient hospital services is determined using a percentage equal to the average of the rates of interest as described in paragraph (a)(1)(ii) of this section.

(2) *Proprietary providers.* For the purposes of this subpart the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

* * * * *

§ 405.430 [Removed]

k. Section 405.430 is removed.

l. Section 405.432 is amended by reprinting the introductory material of paragraph (f) unchanged and adding a new paragraph (f)(4), to read as follows:

§ 405.432 Reasonable cost of physical and other therapy services furnished under arrangements.

* * * * *

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

* * * * *

(4) *Exemptions for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient will be excepted from the guidelines issued under this section if such costs are subject to the provisions of §§ 405.463 or 405.470. The intermediary will grant the exemption without request from the provider.

* * * * *

m. Section 405.434 is amended by reprinting the introductory language of paragraph (c) unchanged, and revising paragraph (c)(3), to read as follows:

§ 405.434 Reasonable cost of extended care services furnished by a swing-bed hospital.

* * * * *

(c) *Principle.* The reasonable cost of extended care services furnished by a swing-bed hospital is determined as follows:

* * * * *

(3) The reasonable cost of ancillary services furnished as extended care services is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with § 405.452(a)(1).

n. Section 405.452 is amended by removing the existing paragraphs (a), (c), (d) and (e), revising paragraph (b) and redesignating it as paragraph (a), and adding new paragraphs (b), (c), (d), and (e). As revised the section reads as follows:

§ 405.452 Determination of cost services to beneficiaries.

(a) *Principle.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:

(1) *Departmental Method*—(i) *Methodology.* Except as provided in paragraph (a)(1)(ii) of this section with respect to the direct apportionment of malpractice costs, and in paragraph (a)(1)(iii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

(ii) *Exception: Malpractice insurance.* For cost reporting periods beginning on or after July 1, 1979, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned to Medicare. The apportionment must be based on the dollar ratio of the provider's Medicare paid malpractice

losses to its total paid malpractice losses for the current cost reporting period and the preceding 4-year period. If a provider has no malpractice loss experience for the 5-year period, the costs of malpractice insurance premiums of self-insurance fund contributions must be apportioned to Medicare based on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. The Health Care Financing Administration will calculate this ratio periodically based on the most recent departmental closed claim study. If a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to Medicare for reimbursement.

(iii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to hospital receiving payment under § 405.470, the additional cost of furnishing services in private room accommodations is apportioned to Medicare only when these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries.

(A) Multiply the average cost per diem (as defined in paragraph (b) of this section) by the total number of Medicare patient days (including private room days whether or not medically necessary).

(B) Add the product of the average per diem private room cost differential (as defined in paragraph (b) of this section) and the number of medically necessary private room days used by beneficiaries.

(C) The days in paragraphs (b)(iii)

(A) and (B) of this section do not include private rooms furnished for SNF type and ICF services under the swing bed provision.

(2) *Carve out method.* (i) The carve out method is used to allocate hospital inpatient general routine service costs in a participating swing-bed hospital, as defined in § 405.434(b). Under this method, the total costs attributable to the SNF-type and ICF-type services furnished to all classes of patients are subtracted from total general routine inpatient service costs before computing the average cost per diem for general routine hospital care.

(ii) The cost per diem attributable to the routine SNF-type services furnished by a swing-bed hospital is based on the reasonable cost per diem for services determined in accordance with § 405.434.

(iii) The cost per diem attributable to the routine ICF services furnished by the swing-bed hospital is determined as follows:

(A) If the hospital is located in a State that provides for ICF services under Medicaid, the cost per diem for ICF services furnished by a swing-bed hospital in that State is based on the Statewide average rate paid for routine services in ICFs (other than ICFs for the mentally retarded) during the preceding calendar year under the State Medicaid plan. The Statewide average rate will be computed either by the State and furnished to HCFA, or by HCFA directly based on the best available data.

(B) If the hospital is located in a State that does not provide for ICF services under Medicaid or that does not have a Medicaid program, the cost per diem for ICF services will be based on the average ratio of the ICF rate to the SNF rate in those States that provide for both SNF and ICF services under Medicaid. The ratio will be applied to the SNF cost per diem determined under paragraph (a)(2)(ii) of this section.

(iv) The sum of (A) total SNF-type days furnished to all classes of patients multiplied by the SNF cost per diem and (B) total ICF-type days furnished to all classes of patients multiplied by the appropriate ICF cost per diem will be subtracted from inpatient general routine service costs. The cost per diem for inpatient general routine hospital care will be based on the remaining general routine service costs.

(v) Costs other than general inpatient routine service costs will be determined in the same manner as specified in the Departmental Method in paragraph (a) of this section.

(b) *Definitions.* As used in this section—

"Ancillary services" means the services for which charges are customarily made in addition to routine services.

"Apportionment" means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients.

"Average cost per diem for general routine services" means the following:

(1) For cost reporting periods beginning on or after October 1, 1982, subject to the provisions on swing-bed hospitals, the average cost of general routine services net of the private room cost differential. The average cost per diem is computed by the following methodology:

(i) Determine the total private room cost differential by multiplying the average per diem private room cost differential determined in paragraph (c) of this section by the total number of private room patient days.

(ii) Determine the total inpatient general routine service costs net of the total private room cost differential by subtracting the total private room cost differential from total inpatient general routine service costs.

(iii) Determine the average cost per diem by dividing the total inpatient general routine service cost net of private room cost differential by all inpatient general routine days, including total private room days.

(2) For swing-bed hospitals, the amount computed by (i) subtracting the costs attributable to SNF-type and ICF-type services from the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and nursery costs), and (ii) dividing the remainder (excluding the total private room cost differential) by the total number of inpatient hospital days of care (excluding SNF-type and ICF-type days of care, days of care in intensive care units, coronary care units, and other intensive care type inpatient hospital units, and newborn days and including total private room days).

"Average cost per diem for hospital intensive care type units" means the amount computed by dividing the total allowable costs for routine services in each of these units by the total number of inpatient days of care rendered in each of these units.

"Average per diem private room cost differential" means the difference in the average per diem cost of furnishing routine services in a private room and in a semi-private room. (This differential is not applicable to hospital intensive care type units.) (The method for computing this differential is described in paragraph (c) of this section.)

"Charges" means the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

"ICF-type services" means routine services furnished by a swing-bed hospital that would constitute intermediate care facility (ICF) services, as defined in § 440.150 of this chapter, if furnished by an ICF. ICF-type services are not covered under the Medicare program.

"Intensive care type inpatient hospital unit" means a hospital unit that furnishes services to critically ill inpatients. Examples of intensive care type units include, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units. (The unit must also meet the criteria of paragraph (d) of this section.)

"SNF-type services" means routine services furnished by a swing-bed hospital that would constitute extended care services if furnished by a skilled nursing facility. SNF-type services include routine services furnished in the distinct part SNF of a hospital complex that is combined with the hospital general routine service area cost center under § 405.453(d)(5).

"Ratio of beneficiary charges to total charges on a departmental basis" means the ratio of charges to beneficiaries of the health insurance program for services of a revenue-producing department or center to the charges to all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of services rendered to beneficiaries of the health insurance program is computed by applying the individual ratio for the center to the cost of the related center for the period.

"Routine services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(c) *Method for computing the average per diem private room cost differential.* Compute the average per diem private room cost differential as follows:

(1) Determine the average per diem private room charge differential by subtracting the average per diem charge for all semi-private room accommodations from the average per diem charge for all private room accommodations. The average per diem charge for private room accommodations is determined by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations. The average per diem charge for semi-private accommodations is determined by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private accommodations.

(2) Determine the inpatient general routine cost/charge ratio by dividing total inpatient general routine service cost by the total inpatient general routine service charges.

(3) Determine the average per diem private room cost differential by multiplying the average per diem private room charge differential determined in paragraph (c)(1) of this section by the ratio determined in paragraph (c)(2) of this section.

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit—(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include critiera for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

(e) *Application.* (1) *Departmental method; Cost reporting periods beginning on or after October 1, 1982.*

(i) The following example illustrates how costs would be determined, using only inpatient data, for cost reporting periods beginning on or after October 1, 1982, based on apportionment of—

(A) The average cost per diem for general routine services (subject to the private room differential provisions of paragraph (a)(1)(iii) of this section);

(B) The average cost per diem for each intensive care type unit;

(C) The ration of beneficiary charges to total charges applied to cost by department.

HOSPITAL Y

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
			Percent		
Operating rooms	$20,000	$70,000	28½	$77,000	$22,000
Delivery rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33⅓	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28½	96,000	28,000
Others	6,000	30,000	20	25,000	5,000
Total	110,000	412,000		350,000	88,000

	Total inpatient days	Total cost	Average cost per diem	Program in patient days	Cost of beneficiary services
General routine	30,000	$630,000	$21	8,000	$168,000
Coronary care unit	500	20,000	40	200	8,000
Intensive care unit	3,000	108,000	36	1,000	36,000
	33,500	758,000		9,200	212,000
Total					300,000

(ii) The following illustrates how apportionment based on an average cost per diem for general routine services is determined.

HOSPITAL E

Facts	Private accommodations	Semi-private accommodations	Total
Total charges	$820,000	$175,000	$195,000
Total days	100	1,000	1,100
Programs days	70	400	470
Medically necessary for program beneficiaries	20		20
Total general routine service costs			165,000
Average private room per diem charge ($20,000 private room charges ÷ 100 days)			[1] $200
Average semi-private room per diem charge ($175,000 semi-private charge ÷ 1,000 days)			[1] $175

[1] Per diem.

Average per diem private room cost differential.

1. Average per diem private room charge differential ($200 private room per diem—$175, semi-private room per diem), $25.

2. Inpatient general routine cost/charge ratio ($165,000 total costs ÷ $195,000 total charges), .8461538.

3. Average per diem private room cost differential ($25 charge differential × .8461538 cost/charge ratio), $21.15.

Average cost per diem for inpatient general routine services.

4. Total private room cost differential ($21.15 average per diem cost differential × 100 private room days), $2,115.

5. Total inpatient general routine service costs net of private room cost differential ($165,000 total routine cost −$2,115 private room cost differential), $162,885.

6. Average cost per diem for inpatient general routine services ($162,885 routine cost net of private room cost differential ÷ 1,100 patient days), $148.08.

Medicare general routine service cost.

7. Total routine per diem cost applicable to Medicare ($148.08 average cost per diem × 470 Medicare private and semi-private patient days), $69,598.

8. Total private room cost differential applicable to Medicare ($21.15 average per diem private room cost differential × 20 medically necessary private room days), $423.

9. Medicare inpatient general routine service cost ($423 Medicare private room cost differential + $69,598 Medicare cost of general routine inpatient services), $70,021.

(9) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

(Determination of cost of routine SNF-type and ICF-type services and general routine hospital services [1])

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care	600	300	
Average medicaid rate	N/A	$35	$20

Total inpatient general routine service costs: $250,000

Calculation of cost of routine SNF-type services applicable to medicare:
$35 × 300 = $10,500

Calculation of cost of general routine hospital services:

Cost of SNF-type services: $35 × 400	$14,000
Cost of ICF-type services: $20 × 100	2,000
Total	$16,000

Average cost per diem of general routine hospital services:
$250,000 − $16,000 ÷ 2,000 days = $117

Medicare general routine hospital cost:
$117 × 600 = $70,200

Total medicare reasonable cost for general routine inpatient days:
$10,500 + $70,200 = $80,700

o. Section 405.453 is amended by adding a new paragraph (f)(3), and removing and reserving paragraph (g) to read as follows:

§ 405.453 Adequate cost data and cost finding.

* * * * *

(f) *Cost reports.* * * *

(3) *Changes in cost reporting periods.* A provider may change its cost reporting period only if—

(i) The provider requests the change in writing from its intermediary;

(ii) The intermediary receives the request at least 120 days before the close of the new reporting period requested by the provider; and

(iii) The intermediary determines that good cause for the change exists. Good cause would not be found to exist if the effect is to change the initial date by which a hospital would be affected by the rate of increase ceiling (see § 405.463), or be paid under the prospective payment system.

(g) [Reserved]

* * * * *

p. Section 405.454 is amended by revising paragraph (a) and adding a new paragraph (m) to read as follows:

§ 405.454 Payments to providers.

(a) *Principle.*

(1) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of reporting period.

(2) *Payments under the prospective payment system.* For cost reporting periods beginning on or after October 1, 1983, hospitals and hospital units (see § 405.401(d)) are paid a prospectively determined rate under §§ 405.470 to 405.477 for Medicare Part A inpatient operating costs on a per discharge basis. Part A inpatient hospital operating costs include those costs (including malpractice costs) for general routine service, ancillary service, and intensive care-type unit services with respect to inpatient hospital services but exclude capital-related and direct medical education costs. Payments for capital-related and direct medical education applicable to inpatient costs that are payable under Part A, for certain kidney acquisition costs of renal transplantation centers (see § 405.2102(e)(1)), and for medical and other health services furnished to inpatients under Part B and outpatient services with respect to such hospitals and hospital units continue on a reasonable basis. The method of payment for hospitals under the prospective payment system is described in paragraph (m) of this section.

* * * * *

(m) *Prospective payments.*

(1) For cost reporting periods beginning on or after October 1, 1983, hospitals will receive payments with respect to Part A inpatient operating costs determined on a per discharge basis using prospectively determined rates. The amounts will represent final payment based on the submission of a discharge bill. Medical education costs and capital-related costs are excluded from prospective payments. For these items, reimbursement on the basis of reasonable costs, using Medicare principles of reimbursement, will continue to apply.

(2) (i) No year end retroactive adjustment is made for prospective payments. However, hospitals meeting the criteria in paragraph (j) of this section may elect to receive periodic interim payments. Therefore, at the discretion of the intermediary, the hospital's prospective payments will be estimated and made on a periodic interim basis (26 biweekly payments). These payments are subject to final settlement. Hospitals electing periodic interim payments may convert to

payments on a per discharge basis at any time.

(ii) For the hospitals receiving periodic interim payments for inpatient operating costs, the biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. These interim payments are reviewed and adjusted at least twice during the reporting period.

(iii) For purposes of determining periodic interim payments under this paragraph, the intermediary computes a hospital's estimated average prospective payment amount by multiplying its transition payment rates as determined under § 405.474(a)(3), but without adjustment by a DRG weighting factor, by the hospital's case-mix index.

(3) For items applicable to inpatient hospital services not reimbursed on a prospective basis (capital-related costs and direct medical education costs), interim payments are made subject to final cost settlement. Interim payments for the estimated cost of capital-related and approved medical education items (applicable to inpatient costs payable under Part A and for kidney acquisition cost in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments.

(4) Payments for the indirect costs of medical education (described in § 405.477(d)(2)) are paid based on an estimate of the total for the Federal portion of the DRG revenue to be received in the current period. The total estimated annual amount of the adjustment will be divided into 26 equal biweekly payments and included with other inpatient costs reimbursed on a reasonable cost basis.

(5) Payments for outlier cases (described in § 405.475) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment regardless of whether or not the provider is receiving periodic interim payments during the period.

q. Section 405.455 is amended by revising paragraphs (a) and (d)(1) and (2)(ii) to read as follows:

§ 405.455 Amount of payments where customary charges for services furnished are less than reasonable cost.

(a) *Principle.* Providers of services, other than comprehensive outpatient rehabilitation facilities, are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. (Payment to comprehensive outpatient rehabilitation facilities is based on the reasonable cost of services.) Public providers of service furnishing services free of charge or at a nominal charge are paid fair compensation for services furnished to beneficiaries. This principle is applicable to services furnished by providers in cost reporting periods beginning after December 31, 1973. This principle does not apply to payments for the costs of Part A inpatient hospital services for cost reporting periods subject to the rate of increase ceiling under § 405.463 or the prospective payment system under § 405.471. However, the carryover from previous periods is recognized, subject to the provisions of paragraph (d) of this section. For special rules concerning HMO's and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 405.2042(b)(14) and 405.2050(c).

* * * * *

(d) *Accumulation of unreimbursed costs and carryover to subsequent periods*—(1) *General.* Any provider of services whose charges are lower than costs in any cost reporting period beginning after December 31, 1973, may carry forward costs attributable to program beneficiaries which are unreimbursed under the provisions of this section for the two succeeding reporting periods. Where beneficiary charges exceed reasonable cost in such subsequent periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such two succeeding cost reporting periods combined include fewer than 24 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period. However, no recovery may be made in any period in which costs are unreimbursed under §§ 405.460 or 405.463.

Example. In the reporting period ending December 31, 1974, the provider's reimbursable costs attributable to covered services furnished program beneficiaries were $100,000. The provider's customary charges for these services were $90,000. The provider will, therefore, be reimbursed $90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed $10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1975, the charges to beneficiaries for covered services exceeded the reimbursable reasonable costs of such services by $10,000 or more, the provider could recover the entire $10,000 previously not reimbursed. If, however, beneficiary charges exceeded costs by $8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount or $2,000 would be carried over to the next reporting period.

(2) *New provider*—(i) *General* * * *

(ii) New provider base period; unreimbursed costs under lower of cost or charges. Where costs of a new provider are unreimbursed under this section, such previously unreimbursed amounts which a provider may recover during any cost reporting period in the new provider base period or carry forward period is limited to the amount by which the aggregate customary charges applicable to health insurance beneficiaries during any such period exceed the aggregate costs applicable to such beneficiaries during that period, except that no recovery may be made in any period in which costs are unreimbursed under §§ 405.460 or 405.463.

* * * * *

r. Section 405.460 is amended by revising paragraph (a)(1), the introductory language of paragraph (e), paragraph (e)(1), the introductory language of paragraph (f), paragraph (f)(9), and paragraph (h), to read as follows:

§ 405.460 Limitations on reimbursable costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1861(v)(1)(A) of the Social Security Act, by setting forth the general rules under which HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments, and sections 1861(v)(7)(B) and 1886(a) of the Social Security Act, by setting forth the general rules under which HCFA may establish limits on the operating costs of inpatient hospital services that are recognized as reasonable in determining Medicare program payments. (For cost reporting periods beginning on or after October 1, 1983, the operating cost incurred in furnishing inpatient hospital services is not subject to the provisions of this section.) This section also sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make

as appropriate in consideration of special needs or situations of particular providers.

* * * * *

(e) *Exemptions.* Exemptions from the limits imposed under this section may be granted in the following circumstances:

(1) *Sole community hospital.*

A sole community hospital is a hospital which, by reason of factors such as isolated location or absence of other hospitals, is the sole source of such care reasonably available to beneficiaries.

* * * * *

(f) *Exceptions.* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section, and may be adjusted upward or downward under the circumstances specified in paragraph (f)(9) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

* * * * *

(9) *Changes in case mix for cost reporting periods beginning before October 1, 1983.* The hospital:

(i) Is subject to limits issued under paragraph (b)(3) of this section for cost reporting periods beginning before October 1, 1983, that are calculated by use of a case-mix index;

(ii) Has added or discontinued services in a year after the year represented in the discharge data used to establish the limits described in paragraph (f)(9)(i) of this section;

(iii) Has experienced a significant and abrupt change in case mix as a result of the addition or deletion of services; and

(iv) Submits discharge data, in the format required by HCFA, for Medicare discharges in the cost reporting period for which the exception is requested.

* * * * *

(h) *Adjustments.* For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, HCFA may adjust the amount of a hospital's inpatient operating costs to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services. Such factors could include a decrease in the inpatient services that a hospital provides that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A decrease in inpatient services could result from changes that include, but are not limited to, such actions as closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

8. Section 405.463 is amended by revising paragraphs (a), (b)(2), (c)(1), (2), (3), and (5), (d), and (h), to read as follows:

§ 405.463 Ceiling on rate of hospital cost increases.

(a) *Introduction.*—(1) *Scope.* This section implements section 1886(b) of the Social Security Act establishing a ceiling on the rate of increase of operating costs per case for inpatient hospital services that will be recognized as reasonable for purposes of determining Medicare reimbursement. This ceiling on allowable rate of cost increases applies to hospital cost reporting periods beginning on or after October 1, 1982 and, for cost reporting periods beginning before October 1, 1983, is applied in addition to the limitations on reasonable cost established under § 405.460. This section also sets forth rules governing exemptions from and exceptions and adjustments to the ceiling.

(2) Applicability. (i) This section is not applicable to hospitals reimbursed in accordance with section 1814(b)(3) of the Act, or under State reimbursement control systems that have been approved under section 1886(c) of the Act.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section is applicable to hospitals excluded from the prospective payment system under § 405.471(c), including subprovider psychiatric and rehabilitation units (distinct parts) and those hospitals eligible for special treatment under the prospective payment system as described in § 405.476(f)(2).

(b) *Cost-reporting periods subject to the rate of increase ceiling.* * * *

(2) *Periods subject to the ceiling.* Ceilings established under this section will be applied to all full 12-month cost reporting periods that:

(i) Immediately follow either a base period as described in paragraph (b)(1) of this section, or another 12-month cost reporting period subject to the ceiling; and

(ii) Begin on or after October 1, 1982.

* * * * *

(c) *Procedure for establishing the ceiling (target amount).*

(1)(i) *Costs subject to the ceiling.* The cost per case ceiling established under this section applies to operating costs incurred by a hospital in furnishing inpatient hospital services. (ii) For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, these operating costs *include* operating costs of routine services (as described in § 405.158(c)), ancillary service operating costs, and special care unit operating costs. These operating costs *exclude* the costs of malpractice insurance, certain kidney acquisition costs, capital-related costs, and costs a hospital allocates to approved medical education programs (nursing school or approved intern and resident programs) on its Medicare cost report.

(iii) For cost reporting periods beginning on or after October 1, 1983, these operating costs exclude only capital-related costs as described in § 405.414, return on equity capital as described in § 405.429, the costs of approved medical education programs as described in § 405.421. Further, kidney acquisition costs incurred by hospitals approved as renal transplantation centers will be reimbursed on a reasonable cost basis. Appropriate adjustments to a hospital's base year costs will be made under paragraph (h) of this section.

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section will be determined on a per discharge basis.

(3) *Target rate percentage.*

(i) The target rate percentage for each calendar year will equal the prospectively estimated increase in the market basket index for that calendar year, plus one percentage point.

(ii) The market basket index is a hospital wage and price index that incorporates appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of inpatient hospital operating costs subject to the ceiling as described in paragraph (c)(1) of this section.

* * * * *

(5) *Applicable target rate percentage.*

(i) The intermediary will use the target rate percentage increase applicable to each 12-month cost reporting period to determine the ceiling on the allowable rate of cost increase under this section.

(ii) When a cost reporting period spans portions of two calendar years, the intermediary will calculate an appropriate prorated percentage rate based on the published calendar year percentage rates.

(iii) The applicable target rate percentage will be the prospectively determined percentage published by HCFA. HCFA will publish quarterly **Federal Register** notices, beginning in 1983, including the applicable estimate of the market basket rate of increase

and the resulting target rate percentage for the next two calendar years. The target rate percentage for each hospital will be based on the percentages published in the latest quarterly notice before the beginning of the hospital's cost reporting period, will be applied prospectively, and will be prorated, in accordance with paragraph (c)(5)(ii) of this section, but will not be retroactively adjusted if the actual market basket rate of increase differs from the estimate.

(d) *Application of target amounts in determining reimbursement*—(1) *General process.*

(i) At the end of each 12-month cost reporting period subject to this section, the hospital's intermediary will compare a hospital's allowable cost per case with that hospital's target amount for that period.

(ii) The hospital's actual allowable costs will be determined without regard to the lower of cost or charges provisions of § 405.455, but, for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, are subject to other limitations on reimbursable cost established under § 405.460.

(iii) If the hospital's actual allowable costs do not exceed the target amount, reimbursement will be determined under paragraph (d)(2) of this section.

(iv) If the hospital's actual costs exceed the target amount, reimbursement will be determined under paragraph (d)(3) of this section.

(2) *Inpatient operating costs are less than or equal to the target amount.* If a hospital's allowable inpatient operating costs per case do not exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined on the basis of the lowest of:

(i) The inpatient operating costs per case plus 50 percent of the difference between the inpatient operating cost per case and the target amount;

(ii) The inpatient operating cost per case plus 5 percent of the target amount; or

(iii) The hospital's allowable inpatient operating cost per case under applicable limits established under § 405.460, if applicable.

(3) *Inpatient operating costs are greater than the target amount.* If a hospital's allowable inpatient operating costs per case exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined as follows:

(i) For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1984, reimbursement will be based on the lower of:

(A) The hospital's target amount plus 25 percent of the allowable operating costs per case in excess of the target amount; or

(B) The hospital's allowable cost per case under applicable limits established under § 405.460, if applicable.

(ii) For cost reporting periods beginning on or after October 1, 1984, reimbursement will be based on the hospital's target amount per case.

* * * * *

(h) *Adjustments*—(1) *Comparability of cost reporting periods.* (i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting period(s), including both periods subject to the ceiling and the hospital's case period, to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.

(ii) In determining the target amount for cost reporting periods beginning on or after October 1, 1983, the intermediary will adjust the base period costs to explicitly include in the costs subject to the ceiling malpractice insurance costs, FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of the program during the base period, but paid under Part A during the subject cost reporting period.

(iii) HCFA may adjust the amount of operating costs, under paragraph (b)(1)(i) of this section, to take into account factors such as a change in the inpatient hospital services that a hospital provides, that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A change in the inpatient hospital services provided could result from changes that include, but are not limited to, opening or closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

(2) *Nursing differential.* Because the Medicare inpatient routine nursing salary cost differential does not apply in the cost reporting periods subject to ceilings established under this section, HCFA will adjust base period costs to remove the effect of this differential.

t. New §§ 405.470 through 405.477, and an undesignated center heading between § 405.466 and § 405.470, are added to read as follows:

Prospective Payment for Inpatient Hospital Services

§ 405.470 Prospective payment: general provisions.

(a) *Scope.*

(1) *Purpose.* Sections 405.470 through 405.477 of this subpart implement section 1886(d) of the Act by establishing a prospective payment system for inpatient hospital services furnished to beneficiaries in cost reporting periods beginning on or after October 1, 1983. Under the prospective payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (capital-related costs, kidney acquisition costs incurred by hospitals with approved renal transplantation centers, and the direct costs of medical education) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, and indirect medical education costs. Under the prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

(2) *Summary of specific sections.* This section describes the basis of payment for inpatient hospital services under the prospective payment system, and sets forth the general basis of this system. Section 405.471 sets forth the classifications of hospitals that are included in and excluded from the prospective payment system, and sets forth requirements governing the inclusion or exclusion of hospitals in the system as a result of changes in their classification. Section 405.472 sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment system. Section 405.473 sets forth the basic methodology by which prospective payment rates are to be determined. Section 405.474 describes the transition rate-setting methods that are to be used to determine transition payment rates during the first three years of the prospective payment system. Section 405.475 sets forth the methodology for determining additional payments for outlier cases. Section 405.476 sets forth special rules for treatment of sole community hospitals, Christian Science Sanitoria, cancer hospitals, referral

centers, and kidney acquisition costs. Section 405.477 describes the types, amounts, and methods of payment to hospitals under the prospective payment system.

(b) *Basis of payment.*

(1) *Payment on a per discharge basis.* Under the prospective payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as described in paragraph (c) of this section) is determined according to the methodology described in §§ 405.473, 405.474, or 405.476, as appropriate. An additional payment is made in accordance with § 405.475 for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(2) *Payment in full.*

(i) The prospective payment amounts paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (b)(3) of this section) incurred in furnishing services covered by the Medicare program.

(ii) The full prospective payment amount, as determined under §§ 405.473, 405.474, and 405.476, is made for each stay during which there is at least one Medicare payable day of care.

(iii) Payable days of care, for purposes of paragraph (b)(2)(ii) of this section, include:

(A) Waiver of liability days payable under § 405.330; and

(B) Guarantee of payment days, as authorized under § 409.68, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(3) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(i) Operating costs for routine services (as described in § 405.452(b)), such as the costs of room, board, and routine nursing services;

(ii) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(iii) Special care unit operating costs (intensive care type unit services, as described in § 405.452(b)); and

(iv) Malpractice insurance costs related to services furnished to inpatients.

(4) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and paid for on a reasonable cost basis:

(i) Capital-related costs, as described § 405.414 and an allowance for return on equity, as described in § 405.429.

(ii) Direct medical education costs, for those approved education programs described in § 405.421.

(iii) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521.

(iv) Kidney acquisition costs incurred by a certified renal transplantation centers.

(5) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates, hospitals will receive payments for:

(i) Outlier cases, as described in § 405.475;

(ii) The indirect costs of graduate medical education (see §§ 405.475(f) and 405.477(d)(2));

(iii) Costs excluded from the prospective payment rate under paragraph (b)(4) of this section (see § 405.477(c)); and

(iv) Bad debts of Medicare beneficiaries (see §§ 405.420 and 405.477(d)(2)).

(c) *Discharges and transfers.*

(1) *Discharges.* A hospital inpatient is discharged when—

(i) The patient is formally released from the hospital (release of the patient to another hospital as described in paragraph (c)(2) of this section will not be recognized as a discharge for the purpose of determining payment under the prospective payment system);

(ii) The patient dies in the hospital; or

(iii) The patient is transferred to a hospital or unit that is excluded from the prospective payment system under § 405.471.

(2) *Transfers.* Except as provided under paragraph (c)(1)(iii) of this section, a discharge of a hospital inpatient is not counted for purposes of the prospective payment system when the patient is transferred—

(i) From one inpatient area or unit of the hospital to another area or unit of the hospital;

(ii) From the care of a hospital paid under this section to the care of another such hospital; or

(iii) From the care of a hospital paid under this section to the care of another hospital—

(A) Excluded from the prospective payment system because of participation in an approved statewide cost control program or demonstration; or

(B) Whose first cost reporting period under the prospective payment system has not yet begun.

(3) *Payment in full to the discharging hospital.* The hospital discharging an inpatient (under paragraph (c)(1) of this section) is paid in full, in accordance with paragraph (b)(2) of this section.

(4) *Payment to a hospital transferring an inpatient to another hospital.* If a hospital paid under the prospective payment system transfers an inpatient to another such hospital, as described in paragraphs (c)(2) (ii) and (iii) of this section, the transferring hospital is paid a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under §§ 405.473 or 405.474 if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under §§ 405.473 or 405.474) by the average length of stay for the specific DRG into which the case falls.

(d) *Cost reporting periods subject to the prospective payment system.*

(1) *Initial cost reporting period.*

(i) Each subject hospital is paid under the prospective payment system for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983.

(ii) The hospital is paid the applicable prospective payment rate for each discharge occurring on or after the first day of its first cost reporting period subject to the prospective payment system.

(iii) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to prospective payment, the reasonable costs of services furnished before that day are reimbursable under the cost reimbursement provisions of this subpart. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for

- Inpatient hospital services furnished to that beneficiary during the hospital stay. Where the amount reimbursed under reasonable cost exceeds the prospective payment amount, the reduction is limited to the prospective payment amount.

(2) *Changes in cost reporting periods.* HCFA will recognize a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 405.453(f)(3).

(e) *Publication of schedule for determining prospective payment rates.*

(1) *Initial prospective payment rates.*

(i) HCFA will publish in the **Federal Register** by September 1, 1983, interim

standardized amounts and DRG weighting factors (determined under § 405.473) as needed to compute prospective payment rates effective for discharges occurring in cost reporting periods beginning on or after October 1, 1983.

(ii) HCFA will publish a notice in the **Federal Register** by December 31, 1983 confirming or modifying the interim initial schedule of standardized amounts and weighting factors. If the resulting interim payment rates are modified, the new rates will apply to discharges occurring after 30 days following the date of publication of this notice.

(2) *Annual publication of schedule for determining prospective payment rates.*

(i) Beginning in 1984, HCFA will publish annual notices setting forth the methodology and data used, including the percentage increase factor, to determine prospective payment rates applicable to discharges occurring during the Federal fiscal year beginning on or after October 1 of that year.

(ii) HCFA will propose changes in the methods, amounts, and factors used to determine prospective payment rates in a **Federal Register** notice published for public comment not later than the June 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(iii) HCFA will publish a **Federal Register** notice setting forth final methods, amounts, and factors for determining prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

(iv) If HCFA does not meet the September 1 publication date requirement of this paragraph, the prospective payment rates in effect on September 1 of the year in question will apply unchanged for the following Federal fiscal year.

§ 405.471 Hospitals and hospital services subject to and excluded from the prospective payment system.

(a) *Hospitals subject to the prospective payment system.*

(1) Except for services described in paragraph (a)(2) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid for under the prospective payment system.

(2) Inpatient hospital services will not be paid for under the prospective payment system if—

(i) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the prospective payment system under paragraphs (b) and (c) of this section;

(ii) The services are emergency services furnished by a nonparticipating hospital in accordance with § 405.152; or

(iii) The services are paid for by a health maintenance organization (HMO) that elects not to have HCFA make payments directly to a hospital for inpatient hospital services furnished to the HMO's Medicare enrollees (see § 405.2040(d)).

(b) *Excluded hospitals: general rules.*

(1) *Criteria.* A hospital will be excluded from the prospective payment system if it meets the criteria for one or more of the excluded classifications described in paragraph (c) of this section.

(2) *Cost reimbursement.* Except for those hospitals specified in paragraph (b)(3) of this section, all excluded hospitals (and distinct part hospital units, as described in paragraph (c)(3)(i) of this section) are reimbursed under the cost reimbursement rules set forth in this subpart, and will be subject to the ceiling on the rate of hospital cost increases described in § 405.463.

(3) *Special reimbursement provisions.* The following classifications of hospitals are reimbursed under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this subpart:

(i) Veterans Administration hospitals.

(ii) Hospitals reimbursed under State cost control systems approved under Part 403 of this chapter.

(iii) Hospitals reimbursed in accordance with demonstrations projects authorized under section 402(a) of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972.

(iv) Nonparticipating hospitals furnishing emergency services to medicare beneficiaries.

(c) *Excluded hospitals and hospital units: classifications.* Hospitals and distinct part units of hospitals that meet the requirements for the classifications set forth in this paragraph may not be reimbursed under the prospective payment system.

(1) *Psychiatric hospitals.* A psychiatric hospital must—

(i) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(ii) Meet the conditions of participation for hospitals (§§ 405.1020 through 405.1035) and special conditions of participation for psychiatric hospitals (§§ 405.1036 through 405.1038).

(2) *Rehabilitation hospitals.* A rehabilitation hospital must—

(i) Have a provider agreement under Part 489 of this chapter to participate as a hospital;

(ii) Have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(A) Stroke.

(B) Spinal cord injury.

(C) Congenital deformity.

(D) Amputation.

(E) Major multiple trauma.

(F) Fracture of femur (hip fracture).

(G) Brain injury.

(H) Polyarthritis, including rheumatoid arthritis.

(iii) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment;

(iv) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;

(v) Have a full-time director of rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship, at least one year of training in the medical management of patients requiring rehabilitation services, or is Board-certified in physiatry, neurology, neurosurgery, orthopedic surgery, or rheumatology;

(vi) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and,

(vii) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment.

(3) *Psychiatric and rehabilitation units (distinct parts).* A psychiatric unit must meet the requirements of paragraphs (c)(3)(i) and (c)(3)(ii) of this section. A rehabilitation unit must meet

the requirements of paragraphs (c)(3)(i) and (c)(3)(iii) of this section.

(i) A distinct part unit must—

(A) Be part of an institution that has in effect an agreement under Part 489 of this chapter to participate as a hospital;

(B) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients;

(C) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available;

(D) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit;

(E) Meet applicable State licensure laws;

(F) Have utilization review standards applicable for the type of care offered in the unit;

(G) Have beds physically separate from (i.e., not commingled with) the hospital's other beds;

(H) Be serviced by the same fiscal intermediary as the hospital;

(I) Be treated as a separate cost center for cost finding and apportionment purposes;

(J) Use an accounting system that properly allocates costs;

(K) Maintain adequate statistical data to support the basis of allocation; and

(L) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

(ii) A psychiatric unit (distinct part) must—

(A) Treat only patients whose primary reason for admission to the unit was for treatment of a diagnosis contained in the Third edition of the American Psychiatric Association's Diagnostic and Statistical Manual;

(B) Be directed by a psychiatrist who is certified by the American Board of Psychiatry and Neurology or is eligible for examination by the Board;

(C) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy;

(D) Have a supervising nurse who is a registered professional nurse qualified in psychiatric or mental health nursing; and

(E) Have a plan of treatment for each patient which is established, reviewed, and revised as needed by a multidisciplinary team consisting of at least a Doctor of Medicine or Osteopathy, a psychologist, and a psychiatric nurse.

(iii) A rehabilitation unit (distant part) must—

(A) Have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(1) Stroke.

(2) Spinal cord injury.

(3) Congenital deformity.

(4) Amputation.

(5) Major multiple trauma.

(6) Fracture of femur (hip fracture).

(7) Brain injury.

(8) Polyarthritis, including rheumatoid arthritis.

(B) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment;

(C) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services;

(D) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and

(E) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment; and

(F) Have a full-time director of rehabilitation who is a Doctor of Medicine or Osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship, at least one year of training in the medical management of patients requiring rehabilitation services, or is Board-certified in physiatry, neurology, neurosurgery, orthopedic surgery, or rheumatology.

(4) *Children's hospitals.* A children's hospital must—

(i) Have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(ii) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 13.

(5) *Long-term hospitals.* A long-term care hospital must—

(i) Have a provider agreement under part 489 of this chapter to participate as a hospital; and

(ii) Have an average length of inpatient stay greater than 25 days—

(A) As computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period; or

(B) If a change in the hospital's average length of stay is indicated, as computed by the same method for the immediately preceding six-month period.

(6) *Hospitals outside the 50 States or the District of Columbia.* A hospital is excluded from the prospective payment system if it is not located in one of the fifty States or the District of Columbia.

(7) *Hospitals reimbursed under special arrangements.* A hospital must be excluded from prospective payment for inpatient hospital services if it is reimbursed under special arrangement as provided in § 405.471(b)(3).

§ 405.472 Conditions for payment under the prospective payment system.

(a) *General requirements.*

(1) A hospital must meet the conditions of this section to receive payment under the prospective payment system for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a hospital fails to comply with these conditions with respect to a particular inpatient hospital stay for a single individual, HCFA may deny payment for that discharge.

(3) If a hospital fails to comply with these conditions with respect to inpatient hospital services furnished to Medicare beneficiaries generally, HCFA may, as appropriate—

(i) Withhold all Medicare payment to the hospital until the hospital provides adequate assurances of future compliance; or

(ii) Terminate the hospital's provider agreement.

(b) *Charges to beneficiaries.*

(1) *Permitted charges-stay covered.* A hospital furnishing covered inpatient hospital services (in accordance with § 405.310(m)) to a Medicare beneficiary for which it expects to receive payment under the prospective payment system may charge that beneficiary for—

(i) The applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter;

(ii) Items and services, furnished at any time during the stay, which are excluded from coverage except for items and services excluded from coverage solely on the basis of requirements at § 405.310(g) (custodial care), § 405.310(k)

(medically unnecessary items and services), or § 405.310(m) (nonphysician services furnished to hospital inpatients by other than a hospital or provider or supplier under arrangements made by a hospital);

(iii) Days of care attributable to a length-of-stay outlier (as described in § 405.475(a)(1)) which—

(A) Are not paid for by Medicare because of the patients' benefits under Medicare are exhausted; or

(B) Are not covered under Medicare Part A for other reasons and waiver of liability under § 405.330 does not apply; (when payment is considered for outlier days, the entire stay is reviewed and days up to the number of days by which the total stay exceeds the outlier day threshold may be denied. In applying this rule, the latest days of the stay will be denied first.);

(iv) Items and services attributable to cost outliers which will not be paid for by Medicare because the services are not covered (for reasons other than exhaustion of benefits) and waiver of liability under § 405.330 does not apply. When payment is considered for cost outliers, the coverage of services throughout the stay will be reviewed. If items and services are denied solely on the basis of § 405.310 (g) or (k), the liability of the beneficiary for those items and services is limited to an amount which, when added to the Medicare payment to the hospital (before application of deductibles and coinsurance), does not exceed the total amount which would have been paid (before application of deductible and coninsurance) if all the services had been viewed as covered.); and

(v) The customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or that of the person acting on his or her behalf).

(2) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hosptial's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

(c) *Admissions and quality review.* Beginning on October 1, 1984 a hospital must have an agreement with a Utilization and Quality Control Peer Review Organization (PRO) to have its admission patterns, length of stays, transfers, services furnished in outlier cases, the validity of diagnostic information, and the quality of its services reviewed on an on-going bases.

(d) *Medical review activities for hospitals paid under the prospective payment system.*

(1) *Admission pattern monitoring (APM).* HCFA will prepare a report which compares a hospital's discharge rate for a quarter with the same hospital's discharge rate for the previous eight quarters. If the hospital's discharge rate increases significantly, the report will be sent to the medical review agent for analysis.

(i) The medical review agent, during the course of its analysis, may request information or records from the hospital, and may conduct on-site medical record review to determine if the increased discharges reflected medically necessary and appropriate admissions.

(ii) If, as a result of analysis under paragraph (d)(1)(i) of this section, the medical review agent finds a pattern of unnecessary or inappropriate admissions, the medical review agent will intensify medical review activities.

(2) *DRG validation.* (i) The attending physician must, shortly before, at or shortly after discharge (but before a claim is submitted), attest to in writing the principal diagnosis, secondary diagnoses, and names of procedures performed.

(ii) The medical review agent will review, every six months, at the hospital, a random sample of discharges for the previous six-month period, to verify that the diagnostic and procedural coding, used by the hospital for DRG assignment, is substantiated by the corresponding medical records.

(iii) If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding or DRG assignment, the hospitals' coding will be appropriately changed and payments recalculated, based on the appropriate DRG assignments.

(iv) If the information attested to by the physician as stipulated under paragraph (d)(2)(i) of this section is found not to be correct, the medical review agent will change the coding and assign the appropriate DRG, based upon the changed coding.

(e) *Denial of payment as a result of admissions and quality review.*

(1) If HCFA determines, based upon information supplied by a medical review agent, that a hospital has misrepresented admissions, discharge, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services funished to beneficiaries, HCFA may as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied under paragraph (e)(1)(i) of this section, and liability is not waived in accordance with §§ 405.330 to 405.332—

(i) If the medical review agent is a PRO, notice and appeals will be provided under procedures established by HCFA to implement the provisions of sections 1155 of the Act, Right to Hearing and Judicial Review.

(ii) If the medical review agent is a PSRO, assuming review in accordance with § 463.26(c)(1), notice and appeals will be provided in accordance with regulations in Part 473 of this chapter, Hearings and Appeals on PSRO determinations.

(iii) If, in the absence of a PRO or PSRO, a fiscal intermediary acts as a medical review agent, notice and appeals will be provided in accordance with regulations in Subpart G of this part, Reconsiderations and Appeals under the Hospital Insurance Program.

(3) A determination made by HCFA under paragraph (e)(1) of this section, related to a pattern of inappropriate admissions and billing practices that have the effect of circumventing the prospective payment system, shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as specified in Part 420 of this chapter. Such determination shall be effective in the manner provided in section 1866(b) (3) and (4) of the Act, and regulations in Part 489 of this chapter, with respect to terminations of agreements, and shall remain in effect until HCFA finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) Any person furnishing services described in paragraph (e)(1) of this section who is dissatisfied with a determination made by HCFA under paragraph (e)(3) shall be entitled to reasonable notice and opportunity for a hearing thereon by HCFA to the same extent as is provided in section 205(b) of the Act and to judicial review of the final decision after such hearing as is provided in section 205(g).

(4) HCFA will promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of the Act of any determination made under the provisions of paragraph (e)(3) of this section.

(f) *All inpatient hospital services furnished either directly or under arrangements.* The applicable payments made under the prospective payment system, as described in § 405.477, are payment in full for all inpatient hospital services, as defined in § 409.10, other than physicians' services to individual patients reimbursable on a reasonable charge basis (in accordance with the criteria of § 405.550(b)). Except as provided in § 489.23 of this chapter, HCFA will not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b). The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3).

(g) *Reporting and recordkeeping requirements.* All hospitals participating in the prospective payment system under this section must meet the recordkeeping and cost reporting requirements of §§ 405.406 and 405.453.

§ 405.473 Basic methodology for determining Federal prospective payment rates.

(a) *DRG classification and weighting factors.*

(1) *Diagnosis-related groups.* HCFA will establish a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(2) *DRG weighting factors.* HCFA will assign an appropriate weighting factor for each DRG that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) *Assignment of Discharges to DRGs.* HCFA will establish a methodology for classifying specific hospital discharges within DRGs that ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(i) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(ii) Each discharge will be assigned to only one DRG (related, except as provided in paragraph (a)(3)(iii) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(iii) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be returned to the hospital for validation and reverification. HCFA's DRG classification system will provide a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(4) *Revision of DRG classification and weighting factors.* HCFA will adjust the classifications and weighting factors established under paragraphs (a) (1) and (2) of this section, for discharges as necessary, but at a minimum for fiscal year 1986 and at least every four fiscal years thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(b) *Federal rates for fiscal year 1984.*

(1) *General rule.* HCFA will determine national adjusted DRG prospective payment rates, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under § 405.471, and will determine regional adjusted DRG prospective payment rates for such discharges in each region, for which payment may be made under Medicare Part A. Such rates will be determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b)(2) through (b)(11) of this section.

(2) *Determining allowable individual hospital costs.* HCFA will determine the Medicare allowable operating costs per discharge of inpatient hospital services for each hospital in the data base for the most recent cost reporting period for which data are available.

(3) *Updating for fiscal year 1984.* HCFA will update each amount determined under paragraph (b)(2) of this section for fiscal year 1984 by:

(i) Updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under paragraph (b)(2) of this section and fiscal year 1983; and

(ii) Projecting for fiscal year 1984 by the applicable percentage increase (as defined in § 405.463(c)(3)) for fiscal year 1984.

(4) *Standardizing amounts.* HCFA will standardize the amount updated under paragraph (b)(3) of this section for each hospital by:

(i) Adjusting for area variations in case mix among hospitals;

(ii) Excluding an estimate of indirect medical education costs;

(iii) Adjusting for area variations in hospital wage levels; and

(iv) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(5) *Computing urban and rural averages.* HCFA will compute an average of the standardized amounts determined under paragraph (b)(4) of this section for urban and rural hospitals in the United States and for urban and rural hospitals in each region.

(6) *Geographic classifications.* For purposes of paragraph (b)(5) of this section:

(i) The term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(ii) The term "urban area" means:

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be urban areas by section 601(g) of the Social Security Amendments of 1983: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(iii) The term "rural area" means any area outside an urban area.

(7) *Adjusting the average standardized amounts.* HCFA adjusts each of the average standardized amounts determined under paragraphs (b)(3) through (b)(5) of this section by factors representing estimates made by HCFA of:

(i) The estimated amount of Medicare payment for nonphysician services to hospital inpatients that would have been paid under Part B during the first cost reporting period subject to propsective payment were it not for the fact that such services must be furnished either directly by hospitals or under arrangements in order for any payment to be made under Medicare after September 30, 1983 (the effective date of § 405.310(m)).

(ii) The estimated amount of FICA taxes that would be incurred during the first cost reporting period subject to the propsective payment system, by hospitals which had not incurred such

taxes for any or all of their employees during the base period described in paragraph (b)(2) of this section.

(8) *Reducing for value of outlier payments.* HCFA reduces each of the adjusted average standardized amounts determined under paragraph (b)(3) through (b)(7) of this section by a proportion equal to the proportion (estimated by HCFA) of the total amount of payments based on DRG prospective payment rates which are additional payments for outlier cases under § 405.475.

(9) *Maintaining budget neutrality.* HCFA adjusts each of the reduced standardized amounts determined under paragraphs (b)(3) through (b)(8) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect April 19, 1983. The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control peer review organization, as allowed under section 1866(a)(1)(F) of the Act.

(10) *Computing Federal rates for urban and rural hospitals in the United States and in each region.* For each discharge classified within a diagnosis-related group, HCFA will establish a national prospective payment rate and will establish a regional prospective payment rate for each region, each of which is equal:

(i) For hospitals located in an urban area in the United States or in that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraphs (b)(3) through (b)(9) of this section) for hospitals located in an urban area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that Diagnosis-Related Group; and

(ii) For hospitals located in a rural area in the United States or in that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraphs (b)(3) through (b)(9) of this section) for hospitals located in a rural area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that Diagnosis-Related Group.

(11) *Adjusting for different wage levels.* HCFA will adjust the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (b)(10) of this section which are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(c) *Federal rates for fiscal years after Federal fiscal year 1984.*

(1) *General rule.* HCFA will determine a national adjusted prospective payment rate, for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under § 405.471, and will determine a regional adjusted prospective payment rate for such discharges in each region, for which payment may be made under Medicare Part A. Each such rate will be determined for hospitals located in urban or rural areas within the United States and within each such region respectively, as described in paragraphs (c)(2) through (c)(6) of this section.

(2) *Updating previous standardized amounts.*

(i) *For fiscal year 1985.* HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section (urban areas and rural areas within the United States, and urban areas and rural areas within each region), equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—

(A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) Adjusted for budget neutrality under paragraph (c)(4) of this section.

(ii) For fiscal year 1986 and thereafter, HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section, equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following.* The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.

(4) *Maintaining budget neutrality for fiscal year 1985.* For fiscal year 1985, HCFA will adjust each of the reduced standardized amounts determined under paragraph (c)(2) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983. The

aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control peer review organization, as allowed under section 1866(a)(1)(F) of the Act.

(5) *Computing Federal rates for urban and rural hospitals.* For each discharge classified within a Diagnosis-Related Group, HCFA will establish for the fiscal year a national prospective payment rate and will establish a regional prospective payment rate, for each region, each of which is equal—

(i) For hospitals located in an urban area in the United States or that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(2) of this section) for the fiscal year for hospitals located in an urban area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group; and

(ii) For hospitals located in a rural area in the United States or that region (respectively), to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(2) of this section) for the fiscal year for hospitals located in a rural area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group.

(6) *Adjusting for different area wage levels.* HCFA will adjust the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (c)(5) of this section which are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 405.474 Determination of transition period payment rates.

(a) General description. (1) *Transition period.* During the initial three-year transition period, payments to all hospitals paid under the prospective payment system will be based on a combination of the Federal prospective payment rates, as determined under § 405.473, and rates based on each hospital-specific rate as determined under paragraph (b) of this section. For the first two years of the transition period, both portions of the payment rates will also be adjusted to ensure budget neutrality. At the end of the transition period (that is, for cost reporting periods beginning on or after October 1, 1986), payments will be based on the national prospective payment rates determined under § 405.473, except for payments which may be made under the specific treatment provisions of § 405.476.

(2) *Payment amounts based on the hospital-specific portion and the Federal portion.* For discharges occurring in cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, the Medicare transition payment rate for a particular covered discharge will equal a blend of the applicable portion of the hospital-specific rate, as determined under paragraph (b) of this section, plus the applicable portions of the Federal national and regional prospective payment rates, as described in paragraph (a)(3) of this section, and summarized in the Table. Payments to new hospitals will be based on the Federal national and regional prospective payment rates, as described in paragraph (a)(4) of this section.

(3) *Amount of blended portions.* The blend of hospital-specific and Federal portions will be as follows:

(i) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984—

(A) 75 percent of the hospital-specific rate; and

(B) 25 percent of the appropriate Federal prospective payment rate.

(ii) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985—

(A) 50 percent of the hospital-specific rate;

(B) 50 percent of the appropriate Federal prospective payment rate.

(iii) For cost reporting periods beginning on or after October 1, 1985, and before October 1, 1986—

(A) 25 percent of the hospital-specific rate;

(B) 75 percent of the appropriate Federal prospective payment rate.

(iv) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. Beginning October 1, 1984, the combined rate is 75 percent regional and 25 percent national. Beginning October 1, 1985, the combined rate is 50 percent regional and 50 percent national. Effective October 1, 1986, the Federal prospective payment rate is 100 percent national.

TABLE—SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING TRANSITION PAYMENT RATES

Cost reporting period beginning on or after	Hospital-specific portion percentage	Federal portion*
October 1, 1983	75	25
October 1, 1984	50	50
October 1, 1985	25	75
October 1, 1986	-	100

*Note: The Federal portion percentages are applied to the combined national or regional prospective payment rates, as appropriate, as determined under § 405.473 for the Federal fiscal year in which the discharge occurs.

(4) *Blended portions for new hospitals.* The prospective payment rates for new hospitals will be a blend of the Federal regional and national rates as follows:

(i) For discharges occurring on or after October 1, 1983 and before October 1, 1984, the prospective payment will equal the appropriate Federal regional rate.

(ii) For discharges occurring on or after October 1, 1984 and before October 1, 1985—

(A) 75 percent of the appropriate Federal regional prospective payment rate; and

(B) 25 percent of the appropriate Federal national rate.

(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986—

(A) 50 percent of the appropriate Federal regional; prospective payment rate; and

(B) 50 percent of the appropriate Federal national prospective payment rate.

(b) Determining the hospital-specific rate. (1) *Base-year costs.*

(i) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 405.470(b)(3), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(ii) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short-period report, with an appropriate adjustment for inflation. (See paragraph (c) of this section for rules applicable to new hospitals.)

(iii) The intermediary will use the best data available at the time in estimating each hospital's base-year costs.

(A) Higher costs that were incurred for purposes of increasing base year costs, or that have the effect of distorting base year costs as an

appropriate basis for computing the hospital-specific rate, or higher costs that result from changes in hospital accounting principles initiated in the base year will be excluded from base year costs for purposes of this section.

(B) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983, may, up to November 15, 1983, have its base period cost per case recomputed, either at the hospital's request or the intermediary's initiative, to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for the purpose of determining base period costs. Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in paragraph (b)(1)(iii)(A) and (b)(2)(ii) of this section.

(iv) The intermediary's estimate of base-year costs is final and may not be changed except as follows:

(A) To correct mathematical errors of calculations. The hospital must report such errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates. The intermediary may also identify such errors and initiate their correction during this period. The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error. Corrections of errors of calculations will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(B) To take into account a successful appeal relating to base period costs. If a hospital successfully contests a disallowance of costs incurred in its base year, the intermediary will recalculate the hospital's base year costs, incorporating the additional costs recognized as allowable as a result of the appeal. Adjustments to base period costs to take into account such previously disallowed costs will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the appeal decision. The hospital's revised base period costs will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the appeal decision.

(c) To exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil money penalty or assessment, a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed based on the final resolution of the amount of the inappropriate base-year costs.

(v) Except as provided in paragraphs (b)(1)(iii)(B) and (b)(1)(iv) of this section, the intermediary's estimate of base-year costs for purposes of determining the hospital-specific portion is final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983.

(2) *Adjustments to base-year cost.*

(i) The intermediary will adjust the hospital's estimated base year inpatient operating costs, as necessary, to eliminate nursing differential costs (as described in § 405.430), direct medical education costs (as described in § 405.421), capital-related costs (as described in § 405.414), and kidney acquisition costs incurred by hospitals approved as renal transplantation centers (as described in § 405.476(h)). Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period. Malpractice insurance costs will be included in the inpatient operating costs, as described in § 405.452.

(ii) A hospital may request the intermediary to further adjust its estimated base period costs to take into account—

(A) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 405.550(b), and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m)), but may not include the costs of anesthetists services for which a physician employer continues to bill under § 405.553(b)(4).

(B) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(iii) If a hospital requests its base period costs to be adjusted under paragraph (b)(2)(ii) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment and adequate data to compute the adjusted costs. The intermediary will determine whether to use part or all of the data based on audit, survey, and other information available.

(3) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(4) *Case-mix adjustment.* The intermediary will divide the adjusted base year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by HCFA), the hospital's base year costs will be divided by the lower of:

(i) The hospital's estimated case-mix index; or

(ii) The average case-mix index for the appropriate classifications of all hospitals subject to cost limits, established under § 405.460 for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

(5) *Outlier adjustment.* The intermediary will reduce the case-mix adjusted base year costs by a percentage equal to the proportion (estimated by HCFA) of the amount of payments based on prospective payment rates that will be additional payments for outlier cases under § 405.475.

(6) *Updating base year costs.*

(i) *For Federal fiscal year 1984.* The case-mix adjusted base year cost per discharge will be updated by the applicable updating factor (that is, the target rate percentage determined under § 405.463(c)), as adjusted for budget neutrality.

(ii) *For Federal fiscal year 1985.* The amount determined under paragraph (b)(6)(i) of this section will be updated by the applicable updating factor, as adjusted for budget neutrality.

(iii) *For Federal fiscal year 1986.* The amount determined under paragraph (b)(6)(ii) of this section will be updated by the applicable updating factor, that is, the target rate percentage determined under § 405.463(c).

(7) *Budget neutrality.*

(i) *Federal Fiscal year 1984.* For cost reporting periods beginning on or after October 1, 1983 and before October 1,

1984, HCFA will adjust the target rate percentage used under paragraph (b)(6) of this section by a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payments made based on the hospital-specific portion of the transition payment rates are neither greater nor less than 75 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the law in effect before April 20, 1983.

(ii) *Federal fiscal year 1985.* For cost reporting periods beginning or or after October 1, 1984 and before October 1, 1985, HCFA will adjust the target rate percentage used under paragraph (b)(6) of this section by a factor actuarially estimated to ensure that the estimated amounts of aggregate Medicare payment made based on the hospital-specific portion of the transition payment rates are neither greater nor less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the Social Security Act as in effect on April 19, 1983.

(8) *DRG adjustment.* The applicable hospital-specific cost per discharge will be multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(c) *Determining transition payment rates for new hospitals.* (1) For purposes of this section, a new hospital is a hospital that:

(i) Is newly participating in the Medicare program (under previous and present ownership); and

(ii) Does not have a 12-month cost reporting period ending before September 30, 1983.

(2) For purposes of computing transition payment rates for a new hospital, HCFA will not use the hospital-specific portion of the prospective payment rate. Payments to new providers will be based solely on the Federal regional and national prospective payment rates, as described in paragraph (a)(4) of this section.

(d) *Recovery of excess transition period payment amounts resulting from unlawful claims.* If a hospital's base year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base period costs will be adjusted to remove the effect of the excess costs, and HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

§ 405.475 Payment for outlier cases.

(a) *General rule.* HCFA will provide for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if—

(1) The beneficiary's length of stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length of stay for the applicable DRG by the lesser of—

(i) A fixed number of days, as specified by HCFA; or

(ii) A fixed number of standard deviations, as specified by HCFA;

(2) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the greater of—

(i) A fixed dollar amount (adjusted for area wage levels) as specified by HCFA; or

(ii) A fixed multiple of the Federal prospective payment rate. During the transition period, the Federal rate is a combination of the national rate and regional rate as follows:

Federal fiscal year	Regional rate percentage	National rate percentage
October 1, 1983	100	
October 1, 1984	75	25
October 1, 1985	50	50
October 1, 1986		100

(b) *Publication and revision of outlier criteria.* HCFA will issue threshold criteria for determining outlier payment in the annual notice of prospective payment rates published in accordance with § 405.470(f).

(c) *Payment for extended length of stay (day outliers).* (1) If the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary will make an additional payment, on a per diem basis, to the provider for those days. A special request or submission by the hospital is not necessary to initiate this payment.

(2) The additional payment will be made only after the medical review agent has reviewed and approved:

(i) The admission;

(ii) The number of outlier days; and

(iii) The validity of the diagnostic and procedural coding.

(3) The per diem payment made under paragraph (c)(1) of this section will be based on 60 percent of the average per diem payment for the applicable DRG, as determined by dividing the Federal prospective payment rate as determined under § 405.475(a)(2)(ii) by the mean length of stay for that DRG.

(4) Any days in the stay identified as noncovered will reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days which occur after the day outlier threshold.

(d) *Payment for extraordinarily high-cost cases (cost outliers).*

(1) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with paragraph (a)(2) of this section.

(2) The hospital must request additional payment within 60 days of receipt of the intermediary's initial determination of the prospective payment rate for the discharge.

(3) The hospital must request medical review agent review and approval of all services. The review, using the medical records and itemized charges will determine that:

(i) The admission was medically necessary and appropriate,

(ii) All services were medically necessary and delivered in the most appropriate setting,

(iii) All services were actually rendered, ordered by the physician, and not duplicatively billed, and

(iv) The diagnostic and procedural coding are correct.

(4) The intermediary will base the cost of the discharge on 72 percent of the billed charges for covered inpatient services. The cost will be further adjusted to exclude an estimate of indirect medical education costs, and to include the reasonable charges for nonphysician services billed by an outside supplier under § 489.23.

(5) If any of the services are determined to be noncovered, the charges for these services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

(6) The additional payment amount will be 60 percent of the difference between the hospital's adjusted cost for the discharge (as determined under paragraph (d)(3) of this section) and the threshold criteria established under paragraph (a)(2) of this section.

(e) *Relation to indirect medical education costs.* The outlier payment amounts will be included in total DRG

revenue for purposes of determining payments for indirect medical education costs under § 405.477(d)(2).

§ 405.476 Treatment of sole community hospitals, Christian Science sanitoria, cancer hospitals, referral centers, and kidney acquisition costs incurred by hospitals approved as renal transplantation centers.

(a) *General rules.*

(1) *Sole community hospitals.* HCFA may adjust the prospective payment rates determined under §§ 405.473 or 405.474 if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under paragraph (b) of this section, its prospective payment rates will be determined under paragraph (c) of this section.

(2) *Christian Science Sanitoria.* HCFA will adjust the prospective payment rates determined under §§ 405.473 or 405.474 if a hospital is a Christian Science sanitorium. Such a sanitorium's prospective payment rates will be determined in accordance with paragraph (e) of this section.

(3) *Hospitals involved extensively in treatment for and research on cancer.* HCFA may adjust the prospective payment rates determined under §§ 405.473 and 405.474 if a hospital is involved extensively in treatment for and research on cancer. Criteria for identifying such hospitals are set forth at paragraph (f) of this section.

(4) *Referral center.* HCFA may make an adjustment to the prospective payment rates determined under §§ 405.473 and 405.474 if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth at paragraph (g) of this section.

(5) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA will pay for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth at paragraph (h) of this section.

(b) *Requests and criteria for classification as a sole community hospital (SCH).*

(1) *Request for classification.* A hospital may request classification as a sole community hospital according to the following procedures:

(i) The hospital must make its request to its fiscal intermediary.

(ii) The intermediary will review the request and will send the request, with its recommendation, to HCFA.

(iii) HCFA will review the request and the intermediary's recommendation and forward its approval or disapproval to the intermediary.

(iv) An approved classification as a sole community hospital will remain in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(2) For purposes of paragraph (b)(3) of this section:

(i) The term "urban area" means:

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be urban areas: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(ii) The term "rural area" means any area outside an urban area.

(3) *Criteria for classification as a sole community hospital.*

(i) A hospital that has been granted an exemption from the hospital cost limits under § 405.460(e)(1) on or before September 30, 1983 will be automatically classified as a sole community hospital under the prospective payment system unless the hospital's classification has been cancelled under paragraph (b)(6) of this section or unless the area in which the hospital is located has been designated as an urban area.

(ii) A hospital will be classified as a sole community hospital if it is located in a rural area; and

(A) The hospital is located more than 50 miles from other like hospitals; or

(B) The hospital is located between 25 and 50 miles from other like hospitals and, either no more than 25 percent of the residents in the hospital's service area are admitted to the other like hospitals for care, or because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least one month out of each year; or

(C) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least one month out of each year.

(4) The term "miles" as used in this section means the distance in miles measured over improved roads. An improved road for this purpose is any road which is maintained by a local, State, or Federal government entity and which is available for use by the general public.

(5) The term "like hospital", as used in this section, means hospitals furnishing short-term, acute care. HCFA will not evaluate comparability of specialty services in making determinations on SCH classification.

(6) *Cancellation of classification.*

(i) A hospital may request to have its classification as a sole community hospital cancelled at any time, and to be paid rates determined under §§ 405.473 or 405.474, as appropriate.

(ii) If a hospital requests to have its sole community hospital classification cancelled, it may not apply later for reclassification as a sole community hospital unless all hospitals within 50 miles of the facility have closed.

(c) *Determining prospective payment rates for sole community hospitals.* For all cost reporting periods beginning on or after October 1, 1983, the prospective payment rates for sole community hospitals will equal 75 percent of the hospital-specific base payment rate (as determined under § 405.474(b)) plus 25 percent of the appropriate regional prospective payment rate (as determined under § 405.473).

(d) *Additional payments to sole community hospitals experiencing a significant volume decrease during the transition period.*

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, HCFA will provide for a payment adjustment for a sole community hospital in any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, more than a 5 percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

(2) To qualify for a payment adjustment due to a decrease in discharges, a sole community hospital must—

(i) Submit documentation to the intermediary demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to extraordinary circumstances beyond the hospital's control. Such circumstance include unusual situations or occurrences externally imposed on the hospital, such as (but not limited to) strikes, fires, earthquakes, floods, inability to recruit essential physician staff, unusual prolonged severe weather

conditions, or similar unusual occurrences with substantial cost effects.

(3) HCFA will determine a per discharge payment adjustment amount, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, based on—

(i) The individual hospital's needs and circumstances, including minimum staffing requirements imposed by State agencies;

(ii) The hospital's fixed (and semi-fixed) costs, other than those costs reimbursed on a reasonable cost basis under this subpart; and

(iii) The length of time the hospital has experienced a decrease in utilization.

(e) *Determining prospective payment rates for Christian Science sanitoria.*

(1) *General rule.* If a Christian Science Sanitorium is not excluded from the prospective payment system under § 405.471, HCFA will pay for inpatient hospital services furnished to a beneficiary by that sanitorium on a basis of a predetermined fixed amount per discharge based on the sanitorium's historical inpatient operating costs per discharge.

(2) *Prospective payment rates.* For cost reporting periods beginning on or after October 1, 1983, the sanitorium's prospective payment rate will be equal to the amount that would constitute the sanitorium's target amount under § 405.463(c)(4) if the institution were subject to the rate of increase ceiling at 405.463 instead of the prospective payment system. This amount will not be adjusted for the DRG weighting factor.

(3) *Outlier payments.* A Christian Science sanitorium is not eligible for outlier payments under § 405.475.

(f) *Cancer hospitals*

(1) *Criteria for classification.* HCFA will consider a hospital's request for an adjustment to a cancer hospital's prospective payment rates only if the hospital—

(i) Was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983;

(ii) Demonstrates that the entire facility is organized primarily for treatment of and research on cancer; and

(iii) Has a patient population such that at least 80 percent of the hospital's total discharges are in Diagnosis-Related Groups incorporating a finding of cancer in the principal diagnosis (that is, the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital).

(2) *Payment.*

(i) A hospital meeting the criteria in paragraph (f)(1) of this section may elect, during its first cost reporting period subject to the prospective payment system, to be reimbursed on a reasonable cost basis under this subpart, subject to the rate of increase limit under § 405.463.

(ii) If the hospital elects reasonable cost reimbursement under paragraph (f)(2)(i) of this section, it will continue to be reimbursed on that basis until it elects to enter the prospective payment system.

(iii) A hospital that does not elect reasonable cost reimbursement under paragraph (f)(2)(i) of this section before the end of its first cost reporting period subject to prospective payment, or that elects to enter the prospective payment system under paragraph (f)(2)(ii) of this section, may not again apply for an adjustment under this paragraph.

(g) *Referral centers.*

(1) *Criteria.* HCFA will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and

(i) Is located in a rural area (as defined in § 405.473(b)(6)) and has 500 or more beds available for use; or

(ii) Has an inpatient population such that at least 60 percent of all Medicare patients reside out-of-state or more than 100 miles from the hospital (whichever is further), and at least 60 percent of all the services it furnishes to beneficiaries are furnished to beneficiaries who reside either out of the State or 100 miles or more from the hospital, whichever is further.

(2) *Payments to rural referral centers with 500 or more beds.* A hospital that meets the criteria of paragraph (g)(1)(i) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473 (b)(10) or (c)(7), as adjusted by the hospital's area wage index.

(h) *Adjustments for renal transplantation centers.*

HCFA will adjust the prospective payment rates determined under § § 405.473 and 405.474 for hospitals approved as renal transplantation centers (described at § § 405.2170 and 405.2171) to remove the estimated net expenses associated with kidney acquisition. Kidney acquisition costs will be treated apart from the prospective payment rate and reimbursement to the hospital will be adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition. Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and recipient evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of recipient with a kidney transplant registry;

(7) Surgeons' fees for excising cadaver kidneys;

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physicians services, such as laboratory, electroencephalography, and surgeon fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

§ 405.477 Payments to hospitals under the prospective payment system.

(a) *Total Medicare payment.* Under the prospective payment system Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in paragraphs (b), (c), and (d) of this section, reduced by the amounts listed in paragraph (e) of this section.

(b) *Payments determined on a per case basis.* A hospital will be paid on a per case basis the following amounts:

(1) The appropriate prospective payment rate for each discharge as determined in accordance with § § 405.473, 405.474, and 405.476;

(2) The appropriate outlier payment amounts determined under § 405.475.

(c) *Payments determined on a reasonable cost basis*—(1) *Capital-related costs.* Payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. For cost reporting periods beginning before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate under § 405.474(b).

(2) *Direct medical education costs.* Payment for the cost of approved medical educational activities as defined in § 405.421 will be made on a reasonable cost basis (except with respect to activities defined in § 405.421(d)). For cost reporting periods beginning prior to October 1, 1986, the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the transition payment rate in § 405.474.

(d) *Additional payments*—(1) *Bad debts.* An additional payment will be made to each hospital in accordance with § 405.420 for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.

(2) *Indirect medical education costs.*

(i) An additional payment may be made to a hospital for indirect medical education costs attributable to an approved graduate medical education.

(ii) To determine the indirect medical education costs, HCFA will determine for each hospital its:

(A) Ratio of full-time equivalent interns and residents to beds, excluding those interns and residents in anesthesiology who are employed to replace anesthetists;

(B) Total revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under § 405.475.

(iii) Based on a comparison of the inpatient operating costs (as defined in § 405.470(b)(3)) of all hospitals, HCFA will determine a factor, expressed as a percentage, representing the effect of teaching activity on operating costs in the same manner as for the limit on hospital inpatient operating costs in effect on January 1, 1983, and will set an education adjustment factor at twice that percentage.

(iv) Each hospital's indirect medical education payment will be determined by multiplying its:

(A) Total DRG revenue, as determined under paragraph (d)(2)(ii)(B) of this section;

(B) A factor representing each 0.1 increase in the hospital's ratio of full-time equivalent interns and residents to beds, as determined under paragraph (d)(2)(ii)(A) of this section; and

(C) The education adjustment factor determined under paragraph (d)(2)(iii) of this section.

(v) The number of full-time equivalent interns and residents under paragraph (d)(2)(ii)(A) will include only interns and residents in teaching programs approved under § 405.421 (excluding those employed by the hospital, but furnishing services at another site), and will equal the sum of:

(A) Interns and residents employed for 35 hours or more per week; and

(B) One half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

(e) *Reductions to total payments*—(1) *Deductible and Coinsurance.* Subject to paragraph (e)(2) of this section, the total Medicare payments otherwise payable to a hospital will be reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§ 409.82, 409.83, and 409.87.

(2) *Payment by Workers' Compensation, Automobile Medical, No-fault or Liability Insurance or an employer Group Health Plan Primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment will be determined in accordance with the following guidelines:

(i) If workers compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321.

(ii) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325.

(iii) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329.

(iv) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and their spouses age 65–69, in accordance with the applicable provisions of §§ 405.340 through 405.344.

(3) HCFA will reduce payments for inpatient hospital services to take into account 100 percent of the reasonable charges (before application of Medicare Part B deductible and coinsurance amounts) for nonphysician services furnished, to beneficiaries entitled to benefits under Medicare Part A, by an outside supplier under § 489.23.

(f) *Effect of change of ownership on payments under the prospective payment system.*

(1) When a hospital's ownership changes, as described in § 489.18 of this chapter, payment for the operating costs of inpatient hospital services for each patient, including outlier payments, as described in paragraph (b) of this section, and payments for indirect medical education costs as described in paragraph (d)(2) of this section, will be made to the legal owner of the hospital at the time of discharge. Payments will not be prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Payment for costs described in paragraphs (c) and (d)(1) of this section, will be made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

4. Section 405.482 is amended by revising paragraph (a) to read as follows:

§ 405.482 Limits on compensation for services of physicians in providers.

(a) *Principle and scope.* (1) Except as provided in paragraphs (a) (2) and (3) of this section, HCFA will establish reasonable compensation equivalent (RCE) limits on the amount of compensation paid to physicians by providers. These limits will be applied to a provider's costs incurred in compensating physicians for services to the provider, as described in § 405.480(a).

(2) Limits established under this section will not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective payment system implemented under §§ 405.470 to 405.477.

(3) Compensation that a physician receives for activites that may not be paid for under either Part A or Part B of

Medicare will not be considered in applying these limits.

* * * * *

4. Subpart E is amended as follows:

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

a. The authority citation for Subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886 and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395(a), 1395u (b) and (h), 1395x (b) and (v), 1395y (a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww and 1395xx).

b. In the table of contents of subpart E, the title of § 405.552 is amended as set forth below:

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement of Services of Hospital Interns, Residents, and Supervisory Physicians

Sec.

* * * * *

405.552 Conditions for payment of charges: Anesthesiology services.

* * * * *

c. Section 405.550 is amended by revising paragraphs (d) (1) and (2) and (e) as follows:

§ 405.550 Conditions for payment of charges for physician services to patients in providers: General provisions.

* * * * *

(d) *Effect of billing charges for physician services to a provider.* (1) If services performed by a physician may be paid for under the reasonable cost rules in §§ 405.480 and 405–481, neither the provider nor physician may seek charge payment for the carrier, beneficiary, or another insurer.

(2) The carrier will not pay on a reasonable charge basis for services furnished by a physician to an individual patient that do not meet the applicable conditions in §§ 405.552, 405.554, and 405.556.

* * * * *

(e) *Effect of physician's assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, under which the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services in the provider, the following rules apply:

(1) The carrier will make reasonable charge payments only for a physician's services to an individual patient.

(2) To the extent the provider incurs a cost reimbursable on a reasonable cost basis under Subpart D of this part, the intermediary will pay the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supply, and equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) will be treated as related to the provider within the meaning of § 405.427.

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

d. In § 405.552, the title and paragraph (a) are revised to read as follows:

§ 405.552 Conditions for payment of charges: Anesthesiology services.

(a) *Services furnished directly or concurrently.* The carrier will reimburse a physician for anesthesiology services furnished to patients in a provider on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in § 405.550(b) and the following additional conditions are met:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated postanesthesia care.

(2) The physician either performs the procedure directly, without the assistance of an anesthetist, or directs no more than four anesthesia procedures concurrently, and does not perform any other services while he or she is directing the concurrent procedures.

* * * * *

e. Section 405.553 is amended by revising paragraph (b) to read as follows:

§ 405.553 Reasonable charges for anesthesiology services.

* * * * *

(b) *Services furnished by the anesthesiologist or by an anesthetist employed by the anesthesiologist.*

(1)(i) The provisions of this paragraph apply to anesthesia services furnished by an anesthesiologist without the assistance of an anesthetist or to anesthesia services furnished to hospital outpatients or SNF or CORF patients by an anesthetist who is employed by an anesthesiologist.

(ii) Except as provided in paragraph (b)(4) of this section, anesthesia services furnished to a hospital inpatient by an anesthetist under the medical direction of an anesthesiologist will be paid for in accordance with paragraph (c) of this section.

(iii) If the anesthetist who administers anesthesia under the direction of the anesthesiologist is employed by the anesthesiologist, the carrier will determine the amount of payment for the services under the reasonable charge rules for physician services in providers in § 405.551 and the general reasonable charge rules in §§ 405.501 through 405.508.

(2) In determining reasonable charges for these anesthesia services, the carrier will allow for no more than one time unit for each 15 minute interval, or fraction thereof, beginning from the time the physician or anesthetist begins to prepare the patient for induction of anesthesia, and ending when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance.

(3) If a physician constructs his or her charges using time units of other than 15 minutes, the carrier will adjust the customary and prevailing charge screens to ensure that in a one-hour period the value of four 15-minute intervals will not be less than would have been allowed if the entire hour had consisted of intervals of another length, such as five 12-minute intervals or six 10 minute intervals.

(4) If the following conditions are met, the provisions of paragraph (b)(1)(ii) of this section do not apply to inpatient hospital services furnished by an anesthetist employed by a physician:

(i) The services are furnished to inpatients of a hospital during a cost reporting period beginning before October 1, 1986.

(ii) It was the physician's practice to employ anesthetists as of the last day of the hospital's most recent 12-month or longer cost reporting period ending before September 30, 1983.

(iii) The cost of the anesthetist services are not added to the hospital's base year costs, as otherwise allowed

under § 405.474(b)(2)(ii)(A), for purposes of determining transition period payment rates under the prospective payment system.

* * * * *

f. Section 405.554 is amended by revising paragraph (b) to read as follows:

§ 405.554 Conditions for payment of charges: Radiology services.

* * * * *

(b) *Services to providers.*—The carrier will not pay on a reasonable charge basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the X-ray films or other items that are interpreted by the radiologist. However, allowable costs for such services will be paid to the provider by the intermediary. (See § 405.480 for provider costs, and § 405.550(e) for costs borne by a physician, such as under a lease or concession agreement.)

g. Section 405.555 is amended by revising paragraph (c)(2) to read as follows:

§ 405.555 Reasonable charges for radiology services.

* * * * *

(c) *Services furnished in providers.*

* * *

* * * * *

(2) The reasonable charge for a physician's radiology service furnished to a hospital inpatient or furnished in a provider to a provider patient may not exceed 40 percent of the prevailing charge for a similar service furnished in a nonprovider setting.

h. Section 405.556 is amended by revising paragraph (a) and adding a new paragraph (c) to read as follows:

§ 405.556 Conditions for payment of charges: Physician laboratory services.

(a) *Physician laboratory services.*—The carrier will reimburse laboratory services furnished by a physician to an individual patient on a reasonable charge basis only if the services meet the conditions for reasonable charge payment in § 405.550(b) and are—

(1) Anatomical pathology services;

(2) Consultative pathology services that meet the requirements in paragraph (b) of this section; or

(3) Services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient.

* * * * *

(c) *Independent laboratory services furnished to hospital inpatients.* Laboratory services furnished to a hospital inpatient by an independent laboratory (as defined in § 405.1310(a)) will be reimbursed on a reasonable charge basis under this Subpart only if they are physician laboratory services as described in paragraph (a) of this section. Payment for nonphysician services furnished to a hospital inpatient by an independent laboratory will be made by the intermediary to the hospital in accordance with Subpart D.

5. Subpart G is amended as follows:

Subpart G—Reconsiderations and Appeals Under the Hospital Insurance Program

a. The authority citation for Subpart G is revised to read as follows:

Authority: Secs. 1102, 1154, 1155, 1869(b), 1871, 1872 and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c, 1395ff(b), 1395hh, 1395ii and 1395pp).

b. Section 405.704 is amended by reprinting the introductory language of paragraph (b) unchanged and revising paragraph (b)(12) to read as follows:

§ 405.704 Actions which are initial determinations.

* * * * *

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under Part A of Medicare, including a determination with respect to:

* * * * *

(12) When items or services are excluded from coverage pursuant to § 405.310(g) or § 405.310(k) or a determination by a Peer Review Organization under section 1154(a)(1) of the Act, whether such individual or the provider of services who furnished such items or services, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage (see § 405.332); and

* * * * *

c. Section 405.706 is revised by designating the single undesignated paragraph as paragraph (a), and adding a new paragraph (b). As revised the section reads as follows:

§ 405.706 Decisions of utilization review committees.

(a) *General rule.* A decision of a utilization review committee is a medical determination by a staff committee of the provider or a group similarly composed and does not constitute a determination by the Secretary within the meaning of section 1869 of the Act. The decision of a utilization review committee may be considered by HCFA along with other pertinent medical evidence in determining whether or not an individual has the right to have payment made under Part A of title XVIII.

(b) *Applicability under the prospective payment system.* HCFA may consider utilization review committee decisions related to inpatient hospital services paid for under the prospective payment system (see §§ 405.470 through 405.477) only as those decisions concern:

(1) The appropriateness of admissions resulting in payments under §§ 405.473, 405.474, and 405.476;

(2) The covered days of care involved in determinations of outlier payments under § 405.475(a)(1); and

(3) The necessity of professional services furnished in high cost outliers under § 405.475(a)(2).

6. Subpart J is amended as set forth below:

Subpart J—Conditions of Participation; Hospitals

a. The Table of Contents for Subpart J is amended by adding the heading for new § 405.1042 and revising the authority citation to read as follows:

Subpart J—Conditions of Participation; Hospitals

Sec.

* * * * *

§ 405.1042 Condition of participation—Special utilization review requirements for hospitals paid under the prospective payment system.

Authority: Sections 1102, 1154(a)(10), 1861 (e), (f), (g), and (k), 1871, and 1886 of the Social Security Act, as amended (42 U.S.C. 1302, 1395x (e), (f), (g), and (k), 1395hh, and 1395ww).

b. New § 405.1042 is added to read as follows:

§ 405.1042 Condition of participation: Special utilization review requirements for hospitals paid under the prospective payment system.

The hospital must have in effect a utilization review plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. The provisions of this section do not apply to a hospital for which a Professional Standards Review Organization or a Utilization and Quality Control Peer Review Organization has assumed binding review.

(a) *Applicability of Utilization Review (UR) plan requirements under titles XVIII and XIX.*

(1) Except as specified in paragraph (a)(2) of this section, for title XVIII purposes the facility must meet the UR requirements specified in this section.

(2) If HCFA determines that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, HCFA may require hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.

(b) *Standard: Composition of utilization review committee.* A UR committee, of which at least two members must be doctors of medicine or Osteopathy, with or without participation of other professional personnel, must carry out the UR functions.

(1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:

(i) A staff committee of the institution;

(ii) A group outside the institution—

(A) Established by the local medical society and some or all of the hospitals in the locality; or

(B) Established in a manner approved by HCFA.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee's or group's reviews may not be conducted by any physician who—

(i) Has a direct financial interest (for example in ownership interest) in the hospital; or

(ii) Was professionally involved in the care of the patient whose case is being reviewed.

(c) *Standard: Scope and frequency of reviews.*

(1) Except as provided in paragraph (c)(2) of this section, the UR plan must provide for review with respect to the medical necessity of—

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals.

(2) In hospitals paid for inpatient hospital services under the prospective payment system (see § 405.470–405.477), the UR plan must provide for:

(i) Review of the duration of stays as required under paragraph (c)(1)(ii) of this section only in cases reasonably assumed by the hospital to be outlier cases based on extended length of stay, as described in § 405.575(a)(1); and

(ii) Review of services furnished as required under paragraph (c)(1)(iii) of this section only in cases reasonably assumed by the hospital to be outlier cases based on extraordinarily high costs, as described in §405.475(a)(2).

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) The UR plan may provide for review of admissions before, at, or after hospital admission.

(d) *Standard: Final determination regarding admissions or continued stays.*

(1) The final determination that an admission or continued stay is not medically necessary—

(i) May be made by one physician on the UR committee in cases where the attending physician concurs with the determination or fails to present his or her views when afforded the opportunity; and

(ii) Must be made by a least two physicians on the UR committee in all other cases.

(2) Before making a final determination that an admission or continued stay is not medically necessary the UR committee must consult the attending physician and afford him or her the opportunity to present his or her views.

(3) If the committee decides that admission to or further stay in the hospital is not medically necessary, written notification must be given—

(i) To the hospital, the attending physicain and the individual;

(ii) No later than two days after the determination;

(iii) No later than two days after the end of the certified period.

(e) *Standard: Extended stay review.*

(1) Except as provided in paragraph (e)(2) of this section, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—

(i) Be the same for all cases; or

(ii) Differ for different classes of cases.

(2) In hospitals paid under the prospective payment system (see §§ 405.470 to 405.477), the UR committee must review all cases reasonably assumed by the hospital to be outlier cases based on extended length of stay (as described in § 405.475(a)(1)).

(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

(f) *Standard: Review of professional services:* The committee must review professinal services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

7. Subpart P is amended as set forth below:

Subpart P—Certification and Recertification; Claims and Benefit Payment Requirements; Check Replacement Procedures

a. The authority citation for Subpart P reads as follows:

Authority: Sections 1102, 1814, 1835, 1871, and 1883, 49 Stat. 647 as amended; 79 Stat. 294; 79 Stat. 303; 79 Stat. 331; 42 U.S.C. 1302, 1395f, 1395n, 1395hh, 1395it, unless otherwise noted.

b. Section 405.1627 is amended by revising paragraphs (a)(1) and (4) and (b) to read as follows:

§ 405.1627 Inpatient hospital services other than inpatient psychiatric or tuberculosis hospital services; certification and recertification for services furnished on or after January 3, 1968.

(a) *General.*

(1) The certification and recertification statement should contain the following information:

(i) An adequate written record of the reasons for:

(A) Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study; or

(B) In the case of certifications or recertifications required under paragraph (b)(2)(i)(B) of this section, special or unusual services;

(ii) The estimated period of time the patient will need to remain in the hospital, or, in the case of certifications or recertifications required under paragraph (b)(2)(i)(B) of this section, the estimated period of time that special or unusual services will be required; and

(iii) Any plans, where appropriate, for posthospital care.

* * * * *

(4) A separate recertification statement is not necessary where the requirements for a second or subsequent recertification are satisfied through utilization review consistent with paragraph (b)(3) of this section. It is sufficient if records of the utilization review committee show that consideration was given to the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

(b) *Timing of certifications and recertifications.*

(1) *For inpatient hospital services that are not paid for under the prospective payment system.* When inpatient

hospital services are not paid for under the prospective payment system (see §§ 405.470 through 405.477), certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. The first recertification is required no later than as of the 18th day of hospitalization. Thereafter, subsequent recertifications are to be made at intervals established by the utilization review committee (on a case by case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days.

(2) *For inpatient hospital services that are paid for under the prospective payment system.*

(i) When inpatient hospital services are paid for under the prospective payment system (see §§ 405.470 through 405.477), certification is required as follows:

(A) In cases reasonably assumed by the hospital to be day outlier cases, certification is required no later than one day after the case reasonably appears to meet the day outlier criteria, established under § 405.475(a)(1), or no later than 20 days into the hospital stay, whichever is earlier. The first recertification is required at an interval to be established by the UR Committee (which can be pursuant to a general rule or on a case by case basis) and subsequent recertifications are to be made consistent with paragraph (b)(1) of this section as it relates to subsequent recertifications.

(B) In cases for which payment may be made or has been requested for a cost outlier, as described in § 405.475(a)(2), certification is required no later than the date on which the hospital requests cost outlier payment, or no later than 20 days into the hospital stay, whichever is earlier, except that, where possible, certification is to occur prior to the hospital incurring costs for which it will seek cost outlier payment. In cost outlier cases, the first recertification and subsequent recertifications are to be made at intervals established by the utilization review committee (on a case by case basis if it so chooses).

(ii) Delayed certifications and recertifications, consistent with § 405.1625(e), are acceptable.

(3) *Option to conduct review of stay of extended duration.* At the option of the hospital, review of a stay of extended duration, pursuant to the hospital's utilization review plan, may take the place of the second and any subsequent physician recertifications required under paragraphs (b)(1) and (b)(2)(i)(A) of this section. Such review may be performed before the date on which such physician recertification would otherwise be required, but would be considered timely if performed as late as the seventh day following such date. The next physician recertification would need to be made no later than the 30th day following such review; if review by the utilization review committee took the place of this physician recertification, the review could be performed as late as the seventh day following such 30th day.

(4) *Description of procedure.* The hospital should have available in the files a written description of the procedure it adopts on timing of certifications and recertifications—that is, the intervals at which the necessary statements are required and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications required under paragraphs (b)(1) and (b)(2)(i)(A) of this section.

c. Section 405.1629 is amended by revising the introductory paragraph to read as follows:

§ 405.1629 Inpatient tuberculosis hospital services and inpatient psychiatric hospital services; certification and recertification.

The requirements for physician certification and recertification for inpatient psychiatric and tuberculosis hospital services are generally similar to the requirements for certification and recertification for inpatient hospital services under § 405.1627. However, for inpatient tuberculosis and psychiatric hospital services, certification is required at the time of admission or as soon thereafter as is reasonable and practicable, and the content of the certification and recertification statements is to conform with the requirements of this section and, in the case of patients admitted to the hospital on or after January 1, 1970, recertification statements are to be obtained in accordance with the intervals set forth in § 405.1627(b)(1). The content requirements differ because of recognition that there frequently is a difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care provided in such hospitals is purely custodial, while the Medicare program's intent is to cover only active care and not to cover custodial care.

* * * * *

d. Section 405.1630 is revised to read as follows:

§ 405.1630 Certification and recertification for beneficiary admitted to a hospital before entitlement to benefits.

(a) *General rule.* If an individual is admitted to a hosptial (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules are applicable when he does become entitled.

(b) *For hospitals that are not included in the prospective payment system.* If the hospital is not included in the prospective payment system under § 405.471, certifications and recertifications are required as of the time they would be required under § 405.1627(b)(1) has the patient been admitted to the hospital on the day he became entitled. Such certifications and recertifications must satisfy the content requirements in § 405.1627(a)(1) in the case of inpatient hospital services; § 405.1629(b) in the case of inpatient psychiatric hospital services; and §405.1629(d) in the case of inpatient tuberculosis hospital services. For example, if a patient becomes entitled on September 1, 1968, but was admitted to a general hospital 1 week prior to that date, the certification is required no later than September 14; the first recertification no later than September 21; subsequent recertifications are required at intervals not to exceed 30 days.

(c) *For hospitals included in the prospective payment system.* If the hospital is included in the prospective payment system under § 405.471, certifications and recertifications are required as of the time they would be required under § 405.1627(b)(2) if the patient had been entitled to benefits on the day he or she was admitted. However, delayed certifications and recertifications, consistent with § 405.1625(e), are acceptable in these cases.

8. Subpart R is amended as set forth below:

Subpart R—Provider Reimbursement Determinations and Appeals

a. The authority citation for Subpart R is revised to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878 and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395, 1395x(v), 1395hh, 1395ii, 1395oo and 1395ww).

b. The table of contents for Subpart R is amended by adding a new § 405.1804 and revising the title of § 405.1835 as follows:

Subpart R—Provider Reimbursement Determinations and Appeals

Sec.

* * * * *

405.1804 Matters not subject to administrative or judicial review under prospective payment.

* * * * *

405.1835 Right to Board hearing.

* * * * *

c. Section 405.1801 is amended by revising the definition of "intermediary determination" in paragraph (a)(1) and revising paragraphs (b) and (c) to read as follows:

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

(1) "Intermediary determination" means the following:

(i) With respect to a provider of services that has filed a cost report under §§ 405.406 and 405.453(f), the term means a determination of the amount of total reimbursement due the provider for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(ii) With respect to a hospital that has filed a cost report and receives payments for inpatient hospital services based on reasonable cost subject to the target rate system (§ 405.463), the term includes a determination of the total amount of payment due the hospital under that system for the period covered by the cost report.

(iii) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (§§ 405.470–405.477), the term includes a determination of the total amount of payment due the hospital under that system for the hospital's cost reporting period covered by the determination.

(iv) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary", as those phrases are used in section 1878(a) of the Act.

(v) For purposes of § 405.374 concerning claims collection activities, the term does not include an action by HCFA with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

* * * * *

(b) *General rule.*

(1) *Providers.* The principles of reimbursement for determining reasonable costs, reasonable cost subject to the target rate, and prospective payment are contained in Subpart D of this part. In order to be reimbursed for covered services furnished to Medicare beneficiaries, providers of services are obliged to file cost reports with their intermediaries as specified in § 405.453(f). Where the term "provider" appears in this subpart, it includes hospitals paid under the target rate or the prospective payment systems for purposes of applying the appeal procedures described in this subpart to those hospitals.

(2) *Other entities participating in Medicare Part A.* In addition to providers of services whose status as such is indicated in the Act, there are entities (such as health maintenance organizations) that do not meet the statutory test for providers of services, which may also participate in Medicare. These entities are required to file periodic cost reports and are reimbursed on the basis of information furnished in the reports. Although the entities do not qualify for Board review, the rules as set forth in this subpart with respect to intermediary hearings are applicable to the entities to the maximum extent possible, for cost-reporting periods ending on or after December 31, 1971, where the amount of program reimbursement in controversy is at least $1,000.

(c) *Effective dates.*

(1) Except as provided in paragraphs (c)(2), (c)(3), and (c)(4) of this section or in § 405.1885(e), this subpart applies to all cost reporting periods ending on or after December 31, 1971, for which reimbursement may be made on a reasonable cost basis.

(2) Sections 405.1835–405.1877 apply only to cost reporting periods ending on or after June 30, 1973, for which reimbursement may be made on a reasonable cost basis.

(3) With respect to hospitals under the reasonable cost subject to target rate system (see § 405.463), the appeals procedures in §§ 405.1811–405.1877 that apply become applicable with a hospital's first cost reporting period beginning on or after October 1, 1982.

(4) With respect to hospitals under the prospective payment system (see §§ 405.470–405.477), the appeals procedures in §§ 405.1811–405.1877 that apply become applicable with the hospital's first cost reporting period beginning on or after October 1, 1983.

d. Section § 405.1803 is revised to read as follows:

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and (ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Target rate.* With respect to a hospital that receives payments for inpatient hospital services under the reasonable cost subject to the target rate system (see § 405.463), the intermediary must include in the notice its determination of the total amount of payment due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) the procedure the intermediary followed under § 405.463 in making its determination.

(3) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see § 405.470–405.477), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by, the hospital during the cost reporting period covered by the notice.

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, HCFA Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also

inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

(c) *Use of notice as basis for recovery of overpayments.* The intermediary's determination as contained in its notice constitutes the basis for making the retroactive adjustment (required by § 405.454(f)) to any program payments made to the provider during the period to which the determination applies, including the suspending of further payments to the provider in order to recover, or to aid in the recovery of, any overpayment identified in the determination to have been made to the provider, notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835. Any suspension will remain in effect as specified in § 405.373(a).

e. A new § 405.1804 is added to read as follows:

§ 405.1804 Matters not subject to administrative and judicial review under prospective payment.

(a) *Limitation.* In accordance with section 1886(d)(7) of the Act, administrative or judicial review under this subpart is precluded for certain aspects of the prospective payment system, as provided in paragraph (b) of this section.

(b) *Subject matter.* Administrative or judicial review is not permitted for controversies about the following matters:

(1) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates.

(2) The establishment of—

(i) Diagnosis related groups (DRGs);

(ii) The methodology for the classification of inpatient discharges within the DRGs; or

(iii) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

f. Section 405.1805 is revised to read as follows:

§ 405.1805 Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary to be a related organization of the provider under § 405.427.

g. Section 405.1809 is revised to read as follows:

§ 405.1809 Intermediary hearing procedures.

(a) *Hearings.* Each intermediary must establish and maintain written procedures for intermediary hearings, in accordance with the regulations in this subpart, for resolving issues that may arise between the intermediary and a provider concerning the amount of reasonable cost reimbursement, reasonable cost subject to the target rate, or prospective payment due the provider (except as provided in § 405.1804) under the Medicare program. The procedures must provide for a hearing on the intermediary determination contained in the notice of program reimbursement (§ 405.1803), if the provider files a timely request for a hearing.

(b) *Amount in controversy.* In order for an intermediary to grant a hearing, the following dates and amounts in controversy apply:

(1) For cost reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy must be at least $1000.

(2) For cost reporting periods ending on or after June 30, 1973, the amount of program reimbursement in controversy must be at least $1000 but less than $10,000.

h. Section 405.1811 is amended by revising paragraphs (a) and (b) to read as follows:

§ 405.1811 Right to intermediary hearing; time, place, form, and content of request for intermediary hearing.

(a) A provider that has been furnished a notice of amount of program reimbursement may request an intermediary hearing if it is dissatisfied with the intermediary's determination contained in the notice and the amount in controversy requirement described in § 405.1809 is met. The request must be in writing and be filed with the intermediary within 180 calendar days after the date of the notice. (See § 405.1835(c)). No other individual, entity, or party has the right to an intermediary hearing.

(b) The request must (1) identify the aspect(s) of the determination with which the provider is dissatisfied, and (2) explain why the provider believes the determination on these matters is incorrect, and (3) be submitted with any documentary evidence the provider considers necessary to support its position.

* * * * *

i. Section 405.1813 is revised to read as follows:

§ 405.1813 Failure to timely request an intermediary hearing.

If a provider requests an intermediary hearing on an intermediary's determination after the time limit prescribed in § 405.1811, the designated intermediary hearing officer or panel of hearing officers will dismiss the request and furnish the provider a written notice that explains the time limitation, except that for good cause shown, the time limit prescribed in § 405.1811 may be extended. However, an extension may not be granted if the extension request is filed more than 3 years after the date of the original notice of the intermediary determination.

j. Section 405.1835 is revised to read as follows:

§ 405.1835 Right to Board hearing.

(a) *Criteria.* The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:

(1) An intermediary determination has been made with respect to the provider; and

(2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841(a)(1); and

(3) The amount in controversy (as determined in § 405.1839(a)) is $10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to hearing based on late intermediary determination about reasonable cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination—see § 405.1803(a)) provided such delay was not occasioned by the fault of the provider.

k. Section 405.1837 is revised to read as follows:

§ 405.1837 Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if—

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or HCFA Rulings; and

(3) The amount in controversy is, in the aggregate, $50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, $50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

l. Section 405.1839 is revised to read as follows:

§ 405.1839 Amount in controversy.

(a) *Single appeals.* The $1000 amount in controversy required under § 405.1809 for an intermediary hearing and the $10,000 amount in controversy required under § 405.1835 for a Board hearing is the combined total of the amounts computed as follows:

(1) By deducting the adjusted total reimbursable program costs due the provider on the basis of reasonable cost from the total reimbursable program costs (less any amounts excluded by section 1862 of the Act) claimed by the provider.

(2) By deducting, as applicable, the total amount of payment due the hospital for inpatient hospital services under the reasonable cost subject to the target rate system or the prospective payment system from the total amount under that system that would be payable after a recomputation that takes into account any exemption, exception, exclusion, adjustment, or additional payment denied the hospital under § 405.463 or §§ 405.470–405.477, as applicable, and for which it has requested a hearing.

(b) *Group appeals.* The $50,000 amount in controversy required under § 405.1837 for group appeals to the Board is the combined total of the amounts computed as follows:

(1) By deducting the adjusted total reimbursable program costs due the provider on the basis of reasonable cost (in the aggregate) from the total reimbursable program costs (less any amounts excluded by section 1862 of the Act) which are claimed in the aggregate by the providers and are related to a common issue or interpretation of law or regulations.

(2) By deducting, as applicable, the total amount of payment due the hospitals (in the aggregate) for inpatient hospital services under the reasonable cost subject to the target rate system or the prospective payment system from the total amount (in the aggregate) under that system that would be payable after a recomputation that takes into account any exemption, exception, exclusion, adjustment, or additional payment denied the hospitals under § 405.463 or §§ 405.470–405.477, as applicable, and for which they have requested a hearing with respect to any matter involving an issue common to the hospitals.

m. Section 405.1841 is revised to read as follows:

§ 405.1841 Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 405.427) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or HCFA Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

n. Section 405.1873 is revised to read as follows:

§ 405.1873 Board's jurisdiction.

(a) *Board decides jurisdiction.* The Board decides questions relating to its jurisdiction to grant a hearing, including (1) the timeliness of an intermediary determination (see § 405.1835(c)), and (2) the right of a provider to a hearing before the Board when the amount in controversy is in issue (see §§ 405.1835(a)(3) and 405.1837).

(b) *Matters not subject to board review.* The determination of a fiscal intermediary that no payment may be made under title XVIII of the Act for any expenses incurred for items and services furnished to an individual because such items and services are excluded from coverage pursuant to section 1862 of the Act, 42 U.S.C. 1395y (see Subpart C of this part), may not be reviewed by the Board. (Such determination shall be reviewed only in accordance with the applicable provisions of Subpart G or H of this part.)

(2) The Board may not review certain matters affecting payments to hospitals under the prospective payment system as provided in § 405.1804.

o. Section 405.1877 is revised to read as follows:

§ 405.1877 Judicial review.

(a) *General rule.* Section 1878(f) of the Act, 42 U.S.C. 1395oo(f), permits providers to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification of a Board decision by the Secretary, by a civil action commenced against the Secretary within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

(b) *Matters not subject to judicial review.* Certain matters affecting payments to hospital under the prospective payment system are not subject to judicial review, as provided in section 1886(d)(7) of the Act and § 405.1804.

(c) *Group appeals.* Any action under this section by providers that are under common ownership or control (see § 405.427) must be brought by the providers as a group with respect to any matter involving an issue common to the providers.

(d) *Venue for appeals.* An action for judicial review must be brought in the District Court of the United States for the judicial district in which the provider if located (or, effective April 20, 1983, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia. Effective April 20, 1983, any action for judicial review by providers under common ownership or control (§ 405.427), must be brought by such providers as a group with respect to any matter involving an issue common to the providers.

(e) *Service of process.* Process must be served as described under 45 CFR Part 4.

9. Subpart T is amended as follows:

Subpart T—Health Maintenance Organizations

a. The authority citation for Subpart T reads as follows:

Authority: Secs. 1102, 1871, and 1876, 49 Stat. 647, as amended, 79 Stat. 331, 86 Stat. 1396 (42 U.S.C. 1302, 1395hh, and 1395mm).

b. Section 405.2041 is amended by revising paragraph (d) to read as follows:

§ 405.2041 Cost reimbursement—general.

* * * * *

(d) An HMO may elect to have providers of services that furnish covered services to enrollees who are title XVIII beneficiaries, obtain reimbursement directly from the health insurance program. The election, which is binding for the entire contract period, must be made in writing to HCFA prior to the beginning of the contract period. When the HMO makes the election, the providers are each paid for covered services they furnish enrollees of the organization in accordance with Subpart D of this part. The amount of such reimbursement will not be included in payments made to the HMO.

B. Part 409, Subpart A, is amended as set forth below:

PART 409—MEDICARE BENEFITS, LIMITATIONS, AND EXCLUSIONS

Subpart A—Hospital Insurance

1. The authority citation for Subpart A is revised to read as follows:

Authority: Secs. 1102, 1812, 1813, 1814, 1866, 1871, 1881, and 1883 of the Social Security Act (42 U.S.C. 1302, 1395d, 1395e, 1395f, 1395x, 1395cc, 1395hh, 1395rr, and 1395tt). Sec. 602(k) of Pub. L. 98-21 (42 U.S.C. 1395y note).

2. Section 409.65 is amended by revising paragraph (e) to read as follows:

§ 409.65 Lifetime reserve days.

* * * * *

(e) *Period covered by election.*

(1) *General rule.* Except as provided in paragraph (e)(2) of this section, an election not to use lifetime reserve days may apply to an entire hospital stay or to a single period of consecutive days in a stay, but cannot apply to selected days in a stay. For example, a beneficiary may restrict the election to the period covered by private insurance but cannot use individual lifetime reserve days within that period. If an election not to use reserve days is effective after the first day on which reserve days are available, it must remain in effect until the end of the stay, unless it is revoked in accordance with § 409.66.

(2) *Exception.* A beneficiary election not to use lifetime reserve days for an inpatient hospital stay for which payment may be made under the prospective payment system (see §§ 405.470-405.477) is subject to the following rules:

(i) If the beneficiary has one or more regular benefit days (see § 409.61(a)(1) of this chapter) remaining in the benefit period upon entering the hospital, an election not to use lifetime reserve days will apply automatically to all days that are not outlier days. The beneficiary may also elect not to use lifetime reserve days for outlier days but this election must apply either to all outlier days or to all outlier days after a specified date.

(ii) If the beneficiary has no regular benefit days remaining in the benefit period upon entering the hospital, an election not to use lifetime reserve days must apply either to the entire hospital stay, to all outlier days, or to all outlier days after a specified date.

3. Section 409.69 is revised to read as follows:

§ 409.69 Amounts payable.

The amounts payable for Medicare Part A services are subject to the deductible and coinsurance requirements set forth in this subpart, and are generally determined in accordance with Part 405, Subpart D of this chapter. (See §§ 405.153(c)(2) and 405.158(a) for payment on a charge basis for certain services furnished by hospitals outside the United States or by hospitals not participating in Medicare.)

C. Part 489 is amended as set forth below:

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

1. The table of contents for Part 489 is amended by adding a new § 489.23 under Subpart B, to read as follows:

Sec.

* * * * *

Subpart B—Essentials of Provider Agreements

489.23 Special provisions for waiver of certain inpatient hospital services requirements.

* * * * *

2. The authority citation for Part 489 is revised to read as follows:

Authority: Secs. 1102, 1861, 1864, 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, and 1395hh).

3. Section 489.3 is revised to read as follows:

§ 489.3 Definition.

"Provider agreement" means an agreement between HCFA and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.

4. Section 489.20 is amended by reprinting the undesignated introductory language unchanged and adding paragraphs (d) and (e) to read as follows:

§ 489.20 Basic commitments.

The provider agrees—

* * * * *

(d) In the case of a hospital that furnishes inpatient hospital services to a beneficiary to either furnish directly or make arrangements for all items and services (other than physicians' services as described in § 405.550(b) of this chapter) for which the beneficiary is entitled to have payment made under Medicare.

(e) In the case of a hospital that furnishes inpatient hospital services for which payment may be made under Subpart D of Part 405 of this chapter, to maintain an agreement with a utilization and quality control peer review organization (if there is such an organization for the area in which the hospital is located, which has a contract with HCFA under Part B of title XI of the

Act) for that organization to review the admissions, quality, appropriateness, and diagnostic information related to such inpatient hospital services.

5. Section 489.21 is amended by reprinting the undesignated introductory language unchanged and adding new paragraphs (e) and (f) to read as follows:

§ 489.21 Specific limitations on charges.

Except as specified in Subpart C of this part, the provider agrees not to charge a beneficiary—

* * * * *

(e) For inpatient hospital services for which a beneficiary would be entitled to have payment made under Part A of Medicare but for a denial or reduction in payments under regulations at § 405.472(e) of this chapter or under section 1886(f) of the Act.

(f) For items and services furnished to a hospital inpatient (other than physicians' services as described in § 405.550(b)) for which Medicare payment would be made if furnished by the hospital or by other providers or suppliers under arrangements made with them by the hospital. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the hospital for the item or service, and is also prohibited.

6. A new § 489.23 is added to read as follows:

§ 489.23 Special provisions for waiver of certain inpatient hospital services requirements.

(a) *General rule.* For any cost reporting period beginning before October 1, 1986, HCFA may waive the requirements of §§ 489.20(d) and 489.21(f), regarding items and services furnished to hospital inpatients, for a hospital that—

(1) Since before October 1, 1982, has extensively followed the practice of allowing suppliers of items and services furnished to the hospital's inpatients to bill directly under Medicare Part B for those items and services.

(2) Could not comply with the requirements of §§ 489.20(d) and 489.21(f) by October 1, 1983 without threatening the stability of patient care furnished to its inpatients.

(b) *Procedure.*

(1) The hospital must submit a written request to its intermediary for a waiver under this section not later than September 10, 1983.

(2) The intermediary will forward the request and their opinion as to whether the hospital meets the criteria for a waiver to the appropriate HCFA Regional Office within 10 days of receipt of the request.

(3) The Regional Office will determine if the hospital's waiver request meets the criteria of paragraph (c) of this section.

(4) The Regional Office will notify the hospital whether its waiver request has been approved not later than October 1, 1983.

(5) The Regional Office's determination to approve or deny a waiver request is final.

(6) The hospital must request revocation of a waiver under this section in writing at least 60 days before the date on which the revocation is to take effect.

(7) Upon 60 days written notice, the Regional Office may revoke a waiver under this section if the outside supplier does not comply with the terms of the billing agreement under paragraph (c)(2) of this section.

(8) Unless a waiver is revoked, it will apply to all cost reporting periods beginning before October 1, 1986.

(c) *Waiver criteria.*

(1) The hospital must show that, before October 1, 1982, a significant proportion of all ancillary services furnished to the hospital's inpatients have been furnished by outside suppliers and directly billed by those suppliers under Medicare Part B.

(2) The criteria in paragraph (c)(1) of this section are met if—

(i) The outside suppliers' reasonable charges for nonphysician services in the hospital's base period (as described in § 405.474(b)(1)) are at least 125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital exclusive of the costs of operating room, recovery room, labor and delivery room, pharmacy, and medical supplies; and

(ii) The hospital's inpatients receive at least three distinct types of ancillary services (such as pathology, radiology, and physical therapy services) primarily from outside suppliers.

(3) The hospital must show that outside suppliers furnishing items and services to its Medicare inpatients under the waiver have agreed that:

(i) The supplier will bill only for services for which payment may be made under Part B (or would be made if the beneficiary were entitled to Part B benefits);

(ii) The supplier will bill the program directly for services furnished to an inpatient of the hospital (even if assignment is not accepted) within 30 days of his or her discharge from the hospital;

(iii) The supplier's billing will specify that the services were furnished to an inpatient of a particular hospital, identify the nonphysician services that were furnished, and identify the charge for each service.

(Catalog of Federal Domestic Assistance Program No. 13.733, Medicare—Hospital Insurance, No. 13774, Medicare—Supplementary Medical Insurance)

Dated: August 26, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 26, 1983.

Margaret M. Heckler,

Secretary.

[**Editorial Note.**—The following addendum will not appear in the Code of Federal Regulations.]

Addendum.—Schedule of Standardized Amounts and Relative Weights Effective With Cost Reporting Periods Beginning on or After October 1, 1983

I. Summary and Background

This addendum sets forth the schedule of standardized amounts and relative weights that will be used to calculate prospective payment amounts under the Medicare program for inpatient, nonphysician services associated with a discharge occurring during cost reporting periods, beginning on or after October 1, 1983, and before October 1, 1984. This schedule is combined, for publication purposes, with the interim final rule implementing the prospective payment system because of the close relationship between this schedule, applicable for fiscal year (FY) 1984, and the rules governing prospective payment as a whole. In the future, notices, similar to this schedule, will be published on or before September 1, of each year, setting forth the schedule of standardized amounts and, if appropriate, relative weights applicable for future periods. The attached preamble to the interim final rule contains a detailed explanation of prospective payment, how the rates have been determined, and its overall relationship to the Medicare program.

II. Calculation of Adjusted Standardized Payment Amounts

This section contains a brief explanation of how the adjusted standardized payment amounts, applicable for FY 84, have been derived. The methodology for arriving at the appropriate rate structure is essentially prescribed in section 1886(d)(2) of the Act.

A. *Base Year Data*

Section 1886(d)(2)(A) of the Act requires the establishment of base year cost data containing allowable operating

costs per discharge of inpatient hospital services for each hospital. See section III C.1.a. of the preamble which contains a detailed explanation of how base year cost data are established.

B. *Updating for Inflation*

Section 1886(d)(2)(B) of the Act requires that the base year cost data be updated for FY 84. A two-step process is necessary.

1. The base year cost data, representing allowable costs per Medicare discharge (per hospital), are inflated through FY 83 using actuarial estimates of the rate of increase in hospital costs nationwide.

2. The resulting amounts are further inflated through FY 84 by using the estimated annual rate of increase in the hospital market basket, plus 1 percentage point, in accordance with the section 1886(b)(3)(B) of the Act.

Since July 1, 1979, the hospital cost limit schedules have incorporated a "market basket index" to reflect changes in the prices of goods and services that hospitals use in producing general inpatient services. We developed the current market basket by identifying the most commonly used categories of hospital inpatient operating expenses and by weighting each category to reflect the estimated proportion of total hospital operating expenses attributable to that category. We then obtained historical and projected rates of increase in the resource prices for each category. Based on the rate of increase and the weight of each category, we developed an overall annual rate of increase in the hospital market basket. The categories of expenses used to develop the revised market basket are based primarily on those used by the American Hospital Association in its analysis of costs, and by the U.S. Department of Commerce in publishing price indexes by industry.

For the purpose of updating base year cost data for FY 84, we revised the market basket previously used under the hospital cost limits, which was published in the **Federal Register** (47 FR 43313) on September 30, 1982. First, we have added malpractice insurance as a new category of expense in the market basket. This change was necessary because malpractice insurance premiums, which were excluded from the hospital cost limits, are to be included under the prospective payment rates. Second, because of the addition of this new category, it was also necessary to revise the relative proportions assigned to each expense category.

Table 2, section VII contains the price variables used to predict price changes for each category of expense. For further background on the development of the market basket index, see Freeland, Anderson and Schendler, "National Hospital Input Price Index", *Health Care Financing Review*, Summer 1979, pp. 37–61.

C. *Standardization*

Section 1886(d)(2)(C) of the Act requires that the updated base year per discharge costs be standardized. Standardization means the removal of the effects of certain causes of variation in cost among hospitals from the cost data.

1. *Variations in Case Mix Among Hospitals*

Section 1886(d)(2)(c)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (i.e., the case-mix index) is comparable to that used for the hospital cost limits published in the **Federal Register** on September 30, 1982 (47 FR 43303). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3, section VII contains the case-mix index values used for this purpose.

2. *Indirect Medical Education Costs*

Section 1886(d)(2)(C)(i) of the Act requires that the updated amounts be standardized for indirect medical education costs. Therefore, after adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix, we divided each cost by 1.0 plus the product of double the education adjustment factor (11.59 percent) and the individual hospital's adjusted intern-and-resident to bed ratio. We determined that adjusted ratio by dividing the hospital's number of FTE interns and residents for the cost reporting period by the hospital's bed size determined at the beginning of the cost reporting period represented in the data base period to obtain the hospital's intern-and-resident to bed ratio, and dividing that ratio by .1. See section III.C.1.c.ii. of the attached preamble which contains an example of the above calculation.

3. *Adjustments for Variation in Hospital Wage Levels*

Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for variations among hospitals in the average area hospital wage level. Therefore, the updated average cost per discharge is divided into labor-related and non labor-related portions. We determined the labor-related portion by multiplying each hospital's cost per discharge by 79.15 percent which is the labor-related portion of costs from the market basket. The labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located to remove the effects of local wage differences from hospital costs. See section III.C.1.c.iii. of the preamble, which contains a detailed explanation of the hospital wage indexes. An example of standardization for area wage differences follows.

Assume a hospital has an average cost per Medicare discharge of $3,000 and the wage index for the area is 1.0293.

$3000 \times 79.15\% = 2374.50$ (labor share)

$\frac{2374.50}{1.0293} = 2306.91$ (wage adjusted labor share)

Table 4, section VII, contains the wage indexes. Basically, the wage index relates wage and employment data, gathered by the Bureau of Labor Statistics, to a single national average. Since the wage index is used for measuring the differences between wages in any area and the national average, the index does not vary with changes in State or census division designations. The variation in adjusted standardized amounts between regions (as shown in Table 1) is significantly less than it would have been if regional wage indexes had been used. We considered but rejected using regional wage indexes for the following reasons:

- Since DRG weighting factors are determined using national cost data, regional wage indexes would have to be converted to a national base to derive the appropriate weighting factor for each DRG.
- The use of regional wage indexes would not result in prospective payment rates that are different from those based on a national wage index.
- Regional wage indexes would confuse hospitals because the numerous base levels would result in index values that could not be directly compared across areas.

4. *Cost-of-Living Factor for Alaska and Hawaii*

Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost-of-living in these States also affects the cost of nonlabor items (e.g., supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (i.e., for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor. Below are the factors used for this adjustment.

TABLE.—COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii—	
Oahu	1.20
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.10

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM-591 letter series.)

The formula used to make the standardization adjustments for the nonlabor related costs in Alaska and Hawaii is as follows:

(Average Cost Per Medicare Discharge) × (20.85%) (Cost-of-Living Adjustment Factor)

D. *Urban-Rural Averages Within Geographic Areas*

Section 1886(d)(2)(D) of the Act requires that average standardized amounts per discharge be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. Table 1, section VII contains the 18 regional standardized amounts (further divided into labor/nonlabor portions). The national standardized amounts are not included in the table because, for FY 84, Federal rates are based on regional averages only. The statute further specifies that the term "urban area" means an area within a Standard Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget (EOMB), or within such similar area as the Secretary has recognized by regulation. As explained in detail in section III.C.1.d. of the preamble, EOMB began using Metropolitan Statistical Areas (MSAs), in lieu of SMSAs, on June 30, 1983. The term "rural area" means any area outside of urban areas.

As a result, the average standardized amounts per Medicare discharge for each hospital have been grouped according to urban or rural designation into the nine census divisions (i.e. 18 separate means).

E. *Adjustments to Average Standardized Amounts*

The average standardized amounts, calculated as described above, were further adjusted as explained below.

1. *Part B Costs*

Section 602(e) of Pub. L. 98–21 amends section 1862(a) of the Act to prohibit payments for nonphysicians services furnished to hospital inpatients unless the services are furnished either directly by the hospital or by an entity under arrangements made by the hospital. Section III.C.1.e.i. of the preamble contains a detailed explanation of this provision. While this provision applies both to inpatient hospital services paid for on the basis of prospective payment rates and to such services paid for on a reasonable cost basis (i.e., furnished by hospitals excluded from prospective payment), it is discussed here only as it applies to adjustments to the standardized amounts for prospective payment.

Essentially, the prospective payment rates are intended to cover all inpatient services except "physicians' services". Since, in the past, many services for inpatients were billed under Part B, the standardized amounts calculated here were derived from data which did not reflect all services provided to inpatients. Therefore, in order to adjust the standardized amounts per discharge so that they represent costs previously billed under Part B, the amounts were increased by .13 percent. This is an estimate of the costs of inpatient hospital services previously billed to HCFA under Part B (updated to reflect 1984 costs) made by HCFA's Office of Financial and Actuarial Analysis.

2. *FICA Taxes*

Section 102 of Pub. L. 98–21 requires that certain hospitals (i.e., non-profit organizations), enter the Social Security system and begin paying FICA taxes for employees beginning January 1, 1984. Section 1886(b)(6) of the Social Security Act is also amended requiring that adjustments be made in the base period costs used to determine the hospital-specific portion of the prospective payment rate (see section III.C.1.e.ii. of the preamble) in recognition of these higher payroll costs. The conference committee report accompanying Pub. L. 98–21 expressed the intent that the Federal rate also be adjusted to reflect this change. HCFA's actuaries have estimated the amount of the adjustment to the standardized amounts necessary to account for additional costs of payroll taxes for hospitals entering the Social Security system to be .18 percent. Therefore, we have increased the standardized amounts by this percentage.

3. *Outliers*

Section 1886(d)(5)(A) of the Act requires that payments, in addition to the basic prospective payment rates, be made for discharges involving day or cost outliers as explained in section III.C.1.e.iii. of the preamble. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion which is estimated to reflect additional payments for outlier cases. The statute further directs that outlier payments may not be less than 5 percent or more than 6 percent of total payments projected to be made based on the prospective payment rates in any year. In accordance with these requirements, we have calculated a factor necessary to adjust standardized amounts for FY 84 to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

4. *Budget Neutrality*

Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98–21. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98–21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- Step 5—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the fiscal year 1984 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above. For a more detailed explanation of budget neutrality, see section VIII of this addendum.

F. *Summary of Calculations Resulting in Adjusted Standardized Amounts*

In summary, we began our calculations by developing base year cost data for individual hospitals; we updated these amounts to account for inflation through fiscal year 1984; we standardized the data for variations in case mix, indirect medical education, area wage levels, and cost-of-living in Alaska and Hawaii; we grouped the data from individual hospitals and calculated average standardized amounts for urban and rural hospitals located in the nine census divisions and the nation; and we adjusted the resulting 18 average amounts in accordance with requirements of the Act. Throughout the remainder of this addendum, when we refer to "adjusted standardized amounts", we are referring to the 18 separate average amounts calculated as described above.

III. Adjustments for Area Wage Levels and Cost-of-Living in Alaska and Hawaii

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the fiscal intermediaries in determining the prospective payment rates as described in section IV below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and non-labor portions. Table 1, section VII contains the actual labor-related and nonlabor-related shares which will be used to calculate the prospective payment rates.

A. *Adjustment for Area Wage Levels*

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional prospective payment rates to account for area differences in hospital wage levels. This adjustment will be made by the fiscal intermediaries by multiplying the labor-related portion of the adjusted standardized amount by the appropriate wage index for the area in which the hospital is located. The wage indexes applicable for fiscal year 1984 are presented in Table 4, section VII of this addendum.

B. *Adjustment for Cost-of-Living in Alaska and Hawaii*

As explained in section III.C.1.c.iv. of the attached preamble the statute provides for an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. The adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the fiscal intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table in section II.C.4. of this addendum.

IV. Federal Prospective Payment Rates

This section contains a brief explanation of how the adjusted standardized amounts are converted to prospective payment rates per dishcharge.

A. *Discharge*

The prospective payment system provides for payment of an amount per discharge. See section III.B.2. of the attached preamble which provides a detailed explanation of discharges and transfers. A "discharge" is defined in the attached regulations at 42 CFR 405.470(c). Generally, a patient will be considered discharged when:

- Formally released from the hospital (but not transferred as explained in section III.B.2 of the preamble);
- The patient dies in the hospital; or
- When the patient is transferred to another institution or unit that is excluded from the prospective payment system.

B. *DRG Classification System*

All inpatient hospital discharges will be categorized according to one of 470 DRGs. (Note that no payment is made for DRG numbers 469 and 470). Every hospital discharge case will fit into a DRG category and no case will apply to more than one category. The assignment is based on the principal diagnosis, secondary diagnoses (if any), procedures performed, and age, sex, and discharge status of the patient. Table 5, section VII, contains the list of DRGs. See section III.B.3 of the preamble, which provides background information regarding the development of the DRG classification system.

C. *DRG Weighting Factors*

We have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG. Each factor reflects the average cost, across all hospitals, of treating cases classified in that DRG relative to all other DRGs. In establishing the weighting factors, we used data from the MEDPAR file, from Medicare cost reports, and from non-Medicare discharge records for Maryland and Michigan hospitals. Table 5, section VII, contains the weighting factors corresponding to each DRG applicable for fiscal year 1984. See Section III.C.3.b of the preamble, which contains a detailed explanation of the calculation of DRG weighting factors.

V. Calculation of Prospective Payment Rates for fiscal year 1984

To ease the sudden impact of a completely new method of payment for hospital services, Pub. L. 98–21 provides for a 3-year transition period. This addendum contains the method that will be used for calculating prospective payment rates for cost reporting periods beginning on or after October 1, 1983.

Section 1886(d)(1)(C)(i) of the Act requires that the prospective payment rate for cost reporting periods beginning on or after October 1, 1983 be a blend of 25 percent of a Federal portion and 75 percent of a hospital-specific portion. See section III.C.4. of the attached preamble, which explains in detail how

the portions will be determined throughout the transition period.

General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or after October 1, 1983 and Before October 1, 1984.

Prospective Payment rate = Hospital – Specific Portion plus Federal Portion

A. *Hospital-Specific Portion*

The hospital-specific portion (HSP) of the prospective payment rate is based on a hospital's historical cost experience. The conference committee report expresses the committee's expectation that the hospital-specific portion be based on the best data available at the time the rate is established for purposes of the transition period. Therefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospital's entry into the prospective payment system. Once the amounts have been calculated, they will be applied without further adjustment throughout the entire 3-year transition period, unless the calculations contain a mathematical error, the hospital successfully appeals their base period allowable costs within the specified time or the facility establishes a distinct part.

The hospital-specific portion is an amount derived from the following formula:

$$\frac{\text{(Base year costs)}}{\text{(Case-mix index)}} \times \text{Outlier adjustment} \times \text{Updating factor} \times \text{75 percent} \times \text{DRG weight}$$

1. Base-year Costs

Base year costs, necessary for calculating the hospital-specific portion of the prospective payment rates, are developed from cost data for the 12-month (or longer) reporting period ending on or after September 30, 1982 and before September 30, 1983. If the applicable period is less than 12 months, then the preceding 12-month (or longer) period is used. Costs in excess of the routine cost limits (i.e., the section 223 limits) will be excluded from base year costs in calculating the hospital-specific portion in the same manner as they are excluded when determining base period costs for the rate-of-increase ceiling under 42 CFR 405.463.

Each hospital's total allowable Part A costs will be adjusted:

- To remove any capital-related costs;
- To remove any medical education costs;
- To remove the nursing differential previously permitted;
- To remove net kidney acquisition costs incurred in hospitals approved as renal transplantation centers;
- To include allowable malpractice insurance costs;
- To include estimated FICA taxes for those hospitals that did not incur such costs in the base period;
- To include the costs of services that were billed under Part B of the program during the base period but will be billed under Part A as inpatient hospital services effective October 1, 1983.

In order to make some of these adjustments, the intermediary must receive documentation from the hospitals as outlined in PRM Chapter 2800 (Transmittal 291).

Total allowable Medicare inpatient operating costs for each hospital, resulting from the above adjustments, are divided by the number of Medicare discharges during the applicable base year. The amount resulting from this calculation will be used as the base year cost per case for purposes of calculating the hospital-specific portion (HSP) of the transition period prospective payment rates.

2. Case-Mix Adjusted Base Year Cost

In order to take into consideration the hospital's individual case mix, the base year cost amount is divided by the case-mix index. (See Table 3, section VII, which contains applicable case-mix indexes.) Adjusted base period costs are divided by the hospital's case-mix index to neutralize them for the effects of the mix of patients treated.

The effects of individual case complexity will be taken into account at the time the rate is applied by multiplying the hospital-specific rate by the weighting factor for the corresponding DRG in which the case is classified to determine the hospital-specific portion of payment for each case.

See section III.C.4.a.ii. of the preamble which contains a detailed explanation of the need for this case-mix adjustment and an explanation of statistically unreliable case-mix indexes.

3. Outlier Adjustment

The case-mix adjusted base year costs are multiplied by a factor calculated to take into account outlier payments of 6.0 percent of total payments. This factor is .943.

4. Budget Neutrality

The hospital-specific portion of the payment rates will be adjusted for cost reporting periods that begin between October 1, 1983 and October 1, 1985, to maintain budget neutrality in accordance with section 1886(e)(1)(A) of the Act. The hospital-specific portion of the rate is set at 75 percent in the first year.

An adjustment will be made to the otherwise applicable target rate percentage to maintain budget neutrality of the hospital-specific portion of the payment. To determine the necessary adjustment we estimated total expenditures under the reasonable cost methodology under TEFRA. The appropriate share of this estimate is compared to a projection of aggregate payments from the hospital-specific portion of the prospective payment amount. For example, if estimated outlays for inpatient operating payments under the law as in effect before April 20, 1983 would have been $10 billion, the total payments under the hospital-specific portion must equal $7.5 billion (75 percent of $10 billion) for fiscal year 1984. In making the above estimates, the statute specifies that payments made or estimated to be made for utilization review activities be excluded. The applicable adjustment factor for maintaining budget neutrality in the hospital-specific portion is .984. This factor has been included in the updating factor discussed in section 5 below. For a more detailed explanation of budget neutrality, see section VIII of this addendum.

5. Updating Factor

The hospital-specific rate is calculated by increasing the case-mix adjusted base year costs (further adjusted for outlier payments as described in paragraph 3. above) by an applicable updating factor in accordance with sections 1886(d)(2)(B) and 1886(e)(1)(A). For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the updating factor is equal to the compounded applicable target rate percentage (as used for the rate-of-increase ceiling under revised 42 CFR 405.463), multiplied by the adjustment factor for budget neutrality (.984) and added to 1. The table below sets forth the updating factors applicable in fiscal year 1984.

If base year cost reporting period ends	And first cost reporting period under PPS ends	Updating factor
Sept. 30, 1982	Sept. 30, 1984	1.13570
Oct. 31, 1982	Oct. 31, 1984	1.13265
Nov. 30, 1982	Nov. 30, 1984	1.12961
Dec. 31, 1982	Dec. 31, 1984	1.12658
Jan. 31, 1983	Jan. 31, 1985	1.12658
Feb. 28, 1983	Feb. 28, 1985	1.12658
Mar. 31, 1983	Mar. 31, 1985	1.12658
Apr. 30, 1983	Apr. 30, 1985	1.12658
May 31, 1983	May 31, 1985	1.12658
June 30, 1983	June 30, 1985	1.12658
July 31, 1983	July 31, 1985	1.12658
Aug. 31, 1983	Aug. 31, 1985	1.12658

If a hospital's base year cost reporting period ends on a day other than those listed above, the update factor for the month nearest to (i.e., either before or after) the actual ending date will be used. For example, if a hospital's cost reporting period ends between October 16 and November 15, the October 31 update factor will be used.

6. Example of Calculation of Hospital Specific Rate

Assume that a hospital's base year costs equal $3,000, its case-mix index is 1.0235, the outlier adjustment is .943, and the update factor for its cost reporting period is 1.14258 percent. The hospital specific rate would be computed as follows:

Base Year Costs / Case-Mix Index	×	Outlier adjustment	×	Updating factor	=	Hospital-specific rate
$3,000 / 1.0235		.943		1.14258		$3,171

7. Calculation of Hospital-Specific Portion

The hospital-specific portion of a hospital's payment rate for a given discharge is calculated by:

Step 1—Multiplying the hospital-specific rate (as determined in subsection 1 through 6 above) by 75 percent, and

Step 2—Multiplying the amount resulting from Step 1 by the specific DRG weighting factor applicable to the discharge (see Table 5, section VII). The result is the hospital-specific portion.

8. New Providers

Hospitals that have not completed a 12 month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983 will be considered new providers for purposes of the prospective payment system. These hospitals do not have any historical cost experience from which we could calculate a hospital-specific rate. Therefore, prospective payment rates for new providers will be computed without regard to the hospital-specific portion. Thus, new providers will be paid 100 percent of the Federal regional rate for discharges occurring on or after October 1, 1983 and before October 1, 1984.

B. *Federal Portion.* For discharges occurring before October 1, 1984, the Federal portion of the prospective payment rate is 25 percent of the Federal regional prospective rate. The Federal rates are determined by:

Step 1—Selecting the appropriate regional adjusted standardized amount considering the location and urban/rural designation of the hospital (See Table 1, section VII);

Step 2—Multiplying the labor-related portion of the standardized amount by the appropriate wage index;

Step 3—For hospitals in Alaska and Hawaii, multiplying the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor;

Step 4—Summing the amounts from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3); and

Step 5—Multiplying the final amount from step 4 by the weighting factor corresponding to the appropriate DRG Classification.

VI. Additional Payment Amounts

In addition to prospective payment rates per discharge, payments will be made for items or services as specified below.

A. *Outliers.* In accordance with the statute, and as explained in the attached preamble (section III.D.1.), additional amounts are to be paid on a per case basis for atypical cases known as "outliers." These cases are those that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG. See § 405.475 of the attached regulations regarding payment for outliers cases.

The statute specifies that outlier payments are to be between 5 and 6 percent of total projected prospective payment amounts. Within this overall requirement, we established as our objectives in FY 84 to define the outlier criteria so that total outlier payments for both types of outlier cases would amount to approximately 6.0 percent of total basic prospective payments (exclusive of outlier payments) that would be payable based on 100 percent of Federal (regional) rates and that approximately 85 percent of the outlier payments would be paid for day outliers and the remaining 15 percent would be paid for high cost outliers.

We analyzed the 1981 MEDPAR file to identify the criteria that would meet our objectives. In doing so, we set the per diem payment for day outliers at 60 percent of the hospital's Federal rate divided by the national geometric mean length of stay for the DRG. For high cost outliers, we set the payment at 60 percent of the difference between adjusted covered charges and the applicable cost criterion for the DRG. We calculated the adjusted covered charges by inflating the covered charges for the case to FY 84, multiplying them by .72 (the national ratio of operating cost to total inpatient charges, and dividing the result by the hospital's educational adjustment factor).

We tested alternative sets of criteria to identify the combination that would result in the desired levels of outlier payments. Based on this analysis, we are providing that a discharge in FY 84 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within that DRG by the lesser of 20 days or 1.94 standard deviations. The first criterion will primarily identify cases in the long-stay resource intensive DRGs whereas the second criterion should identify slightly less than 2 percent of the cases within primarily short-stay DRGs as outliers. In total, we estimate 5.1 percent of all cases will qualify as day outliers.

For fiscal year 1984, we are also providing that a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 1.5 times the Federal rate (regional) for the DRG or $12,000. Both criteria will be adjusted for area wage differences. The first criterion will operate only for the relatively few DRGs with a Federal rate of $6,000 or more. In most cases, the $12,000 criterion will operate. In total, we estimate .9 percent of all cases will qualify as high cost outliers.

For an explanation of payment for alternate placement days, see section III.D.2 of the preamble. In summary, alternate placement days are paid only when a case is in outlier status and are paid the same as outliers.

B. *Additional Payments on Reasonable Cost Basis.*

1. *Capital-Related Costs.* In accordance with the statute, payment for capital-related costs (as described in § 405.414) will be determined on a reasonable cost basis. The capital-related costs must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's

prospective payment rate under § 405.474(b).

2. *Direct Medical Education.* In accordance with the statute, the direct costs of medical education programs will be paid on the basis of reasonable cost subject to applicable regulations at § 405.421.

3. *Direct Medical and Surgical Services of Teaching Physicians.* In accordance with the statute, payment for direct medical and surgical services of physicians in teaching hospitals will be made on a reasonable cost basis under § 405.465 where the hospital exercises the election as provided for in § 405.521(d).

C. *Bad Debts.* An additional payment will be made to each hospital in accordance with § 405.420 for bad debts attributable to deductibles and coinsurance amounts related to covered services received by beneficiaries.

D. *Indirect Medical Education.* Section 1886(d)(5)(8) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method. See section III.D.S. of the preamble for a detailed explanation of additional payments for indirect medical education, and § 405.477(d)(2) of the regulations.

If a hospital has a graduate medical education program approved under 42 CFR 405.421, an additional payment will be made equal to 11.59 percent of the aggregate payments made to the hospital, based on the Federal portion of prospective payments and outlier payments related to those portions, for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents (in approved programs) to its bed size. The number of FTE interns and residents is the sum of:

1. Interns and residents employed for 35 hours or more per week, and

2. One-half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

For purposes of this payment, a hospital will be allowed to count only interns and residents in teaching programs approved under 42 CFR 405.421 who are employed at the hospital. Interns and residents in unapproved programs, interns and residents employed to replace anesthetists, and those who are employed by the hospital but furnish services at another site or in a psychiatric or rehabilitation distinct part unit will not be counted in determining this payment amount. An example of the application of the indirect medical education payment follows:

A 686-bed hospital in Queens County, New York has a total revenue from the Federal portion of the prospective payments of $1.32 million. The hospital employed 77 FTE interns and residents in approved teaching programs on September 30, 1983 (their cost reporting period ending date).

77 divided by 686 = .11224 (ratio of interns and residents to beds) divided by .1 = 1.1224 (adjusted ratio)

Federal portion × teaching adjustment factor × adjusted ratio = additional payment amount.

$1,320,000 × .1159 × 1.1224 = $171,714

VII. Tables

This section contains all tables referred to throughout the preamble to the interim final and this addendum.

TABLE 1.—ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

Region	Urban		Rural	
	Labor related	Nonlabor related	Labor related	Nonlabor related
1. New England (CN, ME, MA, NH, RI, VT)	2,342.75	638.28	2,003.02	484.24
2. Middle Atlantic (PA, NJ, NY)	2,106.03	630.78	1,993.64	491.11
3. South Atlantic (DL, D.C., FL, GA, MD, NC, SC, VA, WV)	2,192.95	584.52	1,803.89	408.07
4. East North Central (IL, IN, MI, OH, WS)	2,340.95	660.40	1,959.42	457.10
5. East South Central (AL, KT, MS, TN)	1,990.97	520.25	1,619.64	381.83
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2,263.48	605.26	1,826.58	392.30
7. West South Central (AR, LA, OK, TX)	2,146.37	572.51	1,762.03	380.42
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,106.90	607.69	1,826.56	426.96
9. Pacific (AK, CA, HA, OR, WA)	2,219.82	711.58	1,908.93	497.87

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Table 2. - HOSPITAL PROSPECTIVE REIMBURSEMENT INPUT PRICE INDEX (the "Market Basket")

Category of costs[1]	Relative Importance[2] 1981	Forecaster,[3] percent changes, 1982-1985	Price variable used
1. Wages and salaries	56.53	DRI-CPS.....	Percentage change in average hourly earnings of hospital industry workers (SIC 806). Source: U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings (monthly).
2. Employee benefits	8.16	DRI-MM.....	Percentage change in supplements to wages and salaries per worker in nonagricultural establishments. Sources: For supplements to wages and salaries - U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business (monthly). July issue has detailed components. For total employment - U.S. Dept. of Labor, Bureau of Labor Statistics, Employment and Earnings (monthly).
3. Professional fees, other (legal, auditing, consulting, etc.)	0.56	DRI-MM.....	Percentage change in hourly earnings index for production or nonsupervisory workers on private nonagricultural payrolls, total private. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
4. Malpractice insurance	2.12	DHHS, HCFA.....	Percentage change in hospital malpractice insurance premiums. Source: Unpublished data compiled by the Health Care Financing Administration. Historical percent changes beginning with 1982 are from the Insurance Services Organization (ISO).
5. Food	3.32	DRI-MM.....	A. Percentage change in food and beverages component of Consumer Price Index, All Urban (relative importance, 1.71). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
		DRI-MM.....	B. Percentage change in processed foods and feeds component of Producer Price Index (relative importance, 1.61). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
6. Fuel and other utilities	3.52	DRI-MM.....	A. Percentage change in implicit price deflator - consumption of fuel oil and coal (derived from fuel oil component of Consumer Price Index) (relative importance, 1.73) Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, Survey of Current Business.
		DRI-MM.....	B. Percentage change in implicit price deflator - consumption of electricity (derived from electricity component of Consumer Price Index) (relative importance, 0.80) Source: U.S. Dept. of Commerce, Bureau of Economic Analysis. Unpublished data provided to Data Resources, Inc. by the Bureau of Economic Analysis. Historical time series data are available from the Health Care Financing Administration or the Bureau of Economic Analysis.
		DRI-MM.....	C. Percentage change in implicit price deflator for natural gas, derived from utility (piped) gas component of Consumer Price Index (relative importance, 0.67). Source: Same as B., electricity, above.

Table 2. - HOSPITAL PROSPECTIVE REIMBURSEMENT INPUT PRICE INDEX (the "Market Basket")

Category of costs[1]	Relative Importance[2] 1981	Forecaster,[3] percent changes, 1982-1985	Price variable used
		DRI-CPS.....	D. Percentage change in water and sewerage maintenance component of Consumer Price Index (relative importance, 0.32). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
7. Drugs	2.61	DRI-CPS.....	Percentage change in pharmaceutical preparations, ethical component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Producer Prices and Price Indexes (monthly), Table 6.
8. Chemicals and cleaning products	2.17	DRI-MM.....	Percentage change in chemicals and allied products components of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
9. Surgical and medical instruments and supplies	2.09	DRI-CPS.....	Percentage change in special industry machinery and equipment component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
10. Rubber and miscellaneous plastics	1.73	DRI-MM.....	Percentage change in rubber and plastic products component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
11. Business travel and motor freight	1.84	DRI-CPS.....	Percentage change in transportation component of Consumer Price Index. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
12. Apparel and textiles	1.45	DRI-MM.....	Percentage change in textile products and apparel component of Producer Price Index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
13. Business services	5.00	DRI-MM.....	Percentage change in services component of Consumer Price Index. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor Review.
14. All other miscellaneous expenses[4]	8.90	DRI-MM.....	Percentage change of Consumer Price Index for all items. All Urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, Monthly Labor REview.
Total	100.00		

[1]Costs not within the scope of the limits (i.e. capital, medical education, and medical professional fees) were excluded in deriving the input price index.

[2]A Laspeyres price index was constructed using 1977 base value weights and the price variables indicated in the table. Base value weights (cost shares) were derived from special studies by the Health Care Financing Administration using primarily data from the American Hospital Association and the Interindustry Economics Division of the Bureau of Economic Analysis, U.S. Department of Commerce. In 1977 each price variable has an index value of 100.00. The "relative importance" changes over time in accordance with price changes for each variable. Cost categories with relatively higher price increases get higher relative importance values and vice versa. For an explanation of the basic methodology used, see Freeland, Mark S., Anderson, Gerard, and Schendler, Carol Ellen, "National Hospital Input Price Index," Health Care Financing Review, Summer 1979, pp. 37-61.

[3]DRI-CPS = Data Resources, Inc., Cost Forecasting Service, 1750 K Street, NW., Washington, D.C. 20006 (Forecast 833). DRI-MM = Data Resources, Inc., Macro Model, 29 Hartwell Avenue, Lexington, Massachusetts 02173 (Trendlong 0783)

[4]This is a residual category of costs not included in the 13 specific categories above. It consists primarily of miscellaneous and unallocated items.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 1

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
01-0001	.9852	* 01-0057	.9686	01-0117	.8900	03-0001	1.1067	03-0064	1.2277
01-0004	.9292	01-0058	1.0098	01-0118	.9385	03-0002	1.2290	03-0065	1.1227
01-0005	1.0134	01-0059	.8585	01-0119	1.0191	03-0003	1.0627	03-0067	.9569
01-0006	1.1006	01-0060	.9637	01-0120	.9346	* 03-0004	.9546	03-0068	1.0042
01-0007	.8912	01-0061	.9109	01-0121	.9376	03-0005	.9971	03-0069	.9869
01-0008	.9718	01-0062	.8962	01-0122	.8813	03-0006	1.1888	03-0070	1.0158
01-0009	.8826	01-0064	1.1158	01-0123	.9277	03-0007	1.0447	* 03-0081	.9167
01-0010	.8842	01-0065	.9792	01-0124	.9376	03-0008	1.0430	04-0001	.9389
01-0011	1.0440	01-0066	.8290	01-0125	.8582	03-0009	1.2163	04-0002	.9696
01-0012	.9722	01-0067	.9057	01-0126	.9575	03-0010	1.1295	04-0003	.9221
01-0014	.8941	01-0068	1.0269	01-0127	.9812	03-0011	1.0386	04-0004	1.1041
01-0015*	.9070	01-0069	.9465	01-0128	.9409	03-0012	.9647	04-0005	.9428
01-0016	1.0052	01-0070	.9310	01-0129	.9362	03-0013	1.1089	04-0006	.9051
01-0017	.9734	01-0072	1.0348	01-0130	.9118	03-0014	1.0825	04-0007	1.0971
01-0018	.8066	01-0073	.9218	01-0131	.8060	03-0016	.9908	04-0008	1.0078
01-0019	.9667	01-0074	.8335	01-0132	.8846	03-0017	1.0508	04-0009	.9171
01-0020	.8956	* 01-0075	.8507	01-0134	.8892	03-0018	1.1135	04-0010	.9737
01-0021	.8749	01-0078	1.0557	* 01-0136	.8258	03-0019	.9815	04-0011	.8466
01-0022	.9486	01-0079	.9873	01-0137	1.1134	03-0020	1.0141	04-0013	.9411
01-0023	1.0350	01-0080	.8676	01-0138	1.0109	03-0022	1.1599	04-0014	.9634
01-0024	.9904	01-0081	1.1292	01-0139	1.1461	03-0023	1.0633	04-0015	.9548
01-0025	.9636	01-0082	.9586	01-0142	.7670	03-0024	1.2056	04-0016	1.1255
01-0026	.5789	01-0083	.9181	01-0143	.9605	03-0025	.9732	04-0017	1.0617
01-0027	.8641	01-0084	.9815	01-0144	.9422	* 03-0026	.8584	04-0018	.9772
01-0028	.9321	01-0085	.9504	01-0145	.9505	03-0027	.9358	04-0019	.8971
01-0029	1.0417	01-0086	.9490	01-0146	.9112	03-0030	1.1025	04-0020	1.0279
01-0030	.9686	01-0087	1.1789	* 01-0147	1.0651	03-0033	1.0059	04-0021	.9896
01-0031	.9615	01-0089	.9310	01-0148	.9206	03-0034	1.0011	04-0022	.9887
01-0032	.8727	01-0090	1.0335	01-0149	1.0685	03-0035	1.0006	04-0024	.9274
01-0033	1.3224	01-0091	1.0037	01-0150	.9657	03-0036	1.0490	04-0025	.9033
01-0034	.8579	01-0092	1.0878	* 01-0151	1.3335	03-0037	1.2471	04-0026	1.0343
01-0035	.9150	01-0094	.8665	* 01-0152	1.1303	03-0038	1.1375	04-0027	1.0504
01-0036	.8431	01-0095	.8548	02-0001	1.1090	* 03-0039	.9586	04-0028	.9798
01-0038	.8893	* 01-0096	.8250	* 02-0002	.9209	03-0040	.9408	04-0029	.9853
01-0039	1.1250	01-0097	.9487	* 02-0004	1.0177	03-0041	.9891	04-0030	.8746
01-0040	1.0180	01-0098	.9372	* 02-0005	.8172	03-0043	1.0309	04-0031	.9531
* 01-0041	.9162	01-0099	.9679	* 02-0006	.5725	03-0044	1.0026	04-0032	.9178
01-0042	.8921	01-0100	1.0522	* 02-0007	.9763	* 03-0046	.9470	04-0033	.8764
01-0044	.8588	01-0101	.8824	02-0008	1.0302	* 03-0047	.9182	04-0035	.9711
01-0045	.8635	01-0102	.9121	* 02-0009	.8583	* 03-0048	1.0781	04-0036	1.0482
01-0046	1.0349	01-0103	1.1826	* 02-0010	1.0603	03-0049	.9377	04-0037	.9515
01-0047	.8284	01-0104	1.1231	* 02-0011	.8499	03-0051	1.0685	04-0039	.9464
01-0048	.9141	01-0108	.9146	02-0012	1.0808	03-0054	1.0038	04-0040	.9523
01-0050	.8993	01-0109	.8935	* 02-0013	.8552	03-0055	1.0446	04-0041	.9741
01-0051	.9815	01-0110	.9393	* 02-0014	.9464	03-0057	1.0562	04-0042	1.0488
01-0052	.8788	* 01-0111	.7712	* 02-0016	1.0212	03-0059	.8912	04-0043	.9039
01-0053	.9076	01-0112	1.0060	02-0017	1.0744	03-0060	.9687	04-0044	.8782
01-0054	1.0025	01-0113	1.0462	* 02-0024	.9003	03-0061	1.1040	04-0045	.8946
01-0055	.9292	01-0114	.9671	* 02-0025	1.1863	03-0062	.9891	04-0047	.9744
01-0056	1.0784	01-0115	.9794	* 02-0026	1.1107	03-0063	1.1397	04-0048	.9765

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 2

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
04-0050	.9526	04-0124	.9450	05-0058	1.0126	05-0115	1.1034	05-0174	1.1936
04-0051	.9651	04-0125	.8485	05-0060	1.0282	05-0116	1.1430	05-0175	1.0239
04-0052	.9207	* 04-0126	.9780	05-0061	1.0225	05-0117	1.1211	05-0177	1.1591
04-0054	.9055	05-0002	1.1385	05-0063	1.0752	05-0118	1.0667	05-0179	1.0400
04-0055	1.0786	05-0004	1.0327	05-0065	1.0174	* 05-0119	.8404	05-0180	1.1148
04-0057	.9252	05-0005	1.0288	05-0066	1.0339	05-0121	.9999	05-0181	.9668
04-0058	.9073	05-0006	1.1518	05-0067	1.0413	05-0122	1.1187	05-0182	.9947
04-0060	.9856	05-0007	1.1022	05-0068	.9389	05-0124	1.0588	05-0183	1.0824
04-0062	1.0553	05-0008	1.0878	05-0069	1.2049	05-0125	1.1113	* 05-0185	.8810
04-0063	1.0360	05-0009	1.1206	05-0070	1.1731	05-0126	1.0191	05-0186	1.0043
04-0064	.9226	* 05-0010	1.0116	05-0071	1.0732	05-0127	1.1234	05-0187	1.0359
04-0066	.9167	05-0011	.9354	05-0072	1.0956	05-0128	1.0531	05-0188	1.0902
04-0067	.9235	05-0013	1.2513	05-0073	1.0940	05-0129	1.1500	05-0189	.9212
04-0068	.9588	05-0014	1.0081	05-0074	.9628	05-0131	1.1071	* 05-0190	.9895
04-0069	.9488	05-0015	1.0016	05-0075	1.1624	05-0132	1.0643	05-0191	1.0849
04-0070	.9115	05-0016	1.0410	05-0076	1.1348	05-0133	1.0023	05-0192	1.0037
04-0071	1.0258	05-0017	1.1733	05-0077	1.1256	05-0134	1.0381	05-0193	1.0351
04-0072	.9259	05-0018	1.0222	05-0078	1.0842	05-0135	1.0607	05-0194	1.0166
04-0074	.9664	05-0019	.8854	05-0079	1.1006	05-0136	1.0472	05-0195	1.0233
04-0075	.9705	* 05-0020	1.0482	05-0080	1.0622	05-0137	1.0703	05-0196	1.0938
04-0076	.9283	05-0021	1.0188	05-0081	1.1310	05-0138	1.1345	05-0197	1.1920
04-0077	.9189	05-0022	1.0812	05-0082	1.0461	05-0139	1.1072	05-0199	.9775
04-0078	.9827	05-0024	1.0932	05-0084	1.2228	05-0140	1.0790	05-0200	1.0114
04-0080	.9183	05-0025	1.1997	05-0085	1.1193	05-0141	1.0617	05-0201	1.0076
04-0081	.8732	05-0026	1.0994	* 05-0086	1.1714	05-0143	.9257	05-0202	1.0306
04-0082	.9355	05-0028	1.1142	05-0087	1.1316	05-0144	1.1692	05-0204	1.1812
04-0084	.9617	05-0029	1.1326	* 05-0088	1.0211	05-0145	1.1063	05-0205	1.1367
04-0085	.9383	05-0030	1.0527	05-0089	1.0871	05-0146	1.1302	05-0207	1.1068
04-0087	.9332	* 05-0031	1.0965	05-0090	1.0779	* 05-0147	.9817	05-0208	1.0878
04-0088	1.0211	05-0032	.9707	05-0091	.9535	05-0148	1.0125	05-0210	1.0813
04-0090	.9449	05-0033	1.0855	05-0092	1.0324	05-0149	1.0185	05-0211	1.0585
04-0091	.9376	05-0034	1.0090	05-0093	1.1938	05-0150	1.1131	05-0212	.9981
04-0092	.8671	05-0036	1.0962	05-0095	.9543	05-0151	1.0858	05-0213	1.0898
04-0095	.8956	05-0038	1.1626	05-0096	1.0251	05-0152	1.0843	05-0214	1.0915
04-0096	1.0614	05-0039	1.2292	05-0097	1.0619	05-0153	1.1884	05-0215	1.1320
04-0100	.9924	05-0040	1.0349	05-0098	.9974	05-0154	1.0767	05-0217	1.0607
04-0105	1.0183	05-0041	.9848	05-0099	1.0963	05-0155	1.0277	05-0219	1.1221
04-0106	.9498	05-0042	1.0266	05-0100	1.2490	05-0156	1.1163	05-0220	.9967
04-0107	.9721	05-0043	1.2187	05-0101	1.1182	05-0158	1.0694	05-0221	1.1069
04-0108	.8972	05-0045	1.0441	05-0102	1.0768	05-0159	1.0142	05-0222	1.0517
04-0109	.9786	05-0046	1.1551	05-0103	1.1692	05-0161	1.0142	05-0224	1.0852
* 04-0113	.8520	05-0047	1.2084	05-0104	1.0904	05-0162	.8979	05-0225	1.0448
04-0114	1.1386	05-0049	1.1119	05-0107	1.0585	05-0164	1.1066	05-0226	1.0850
04-0115	.9741	05-0051	1.0122	05-0108	1.0811	* 05-0166	1.0496	05-0228	1.0938
04-0116	1.0959	* 05-0052	.9275	05-0109	1.3608	05-0167	1.1218	05-0229	1.0446
04-0118	.9936	05-0053	1.0955	05-0110	.9176	05-0168	1.1716	05-0230	1.0127
04-0119	.9330	05-0054	1.0502	05-0111	1.1660	05-0169	1.1219	05-0231	1.0750
* 04-0121	.8541	05-0055	1.0378	05-0112	1.1477	05-0170	1.0584	05-0232	1.0588
04-0122	1.0113	05-0056	1.0363	05-0113	.9883	05-0172	1.2717	05-0233	1.0372
04-0123	.8984	05-0057	1.0244	05-0114	1.0449	05-0173	.9447	05-0234	.9944

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3.a HOSPITAL CASE MIX INDEXES Page 3

PROVIDER NUMBER	CASE MIX INDEX
05-0235	1.1215
05-0236	1.0357
05-0238	1.0586
05-0239	1.1063
05-0240	1.0716
05-0241	1.0493
05-0242	1.1156
05-0243	1.0036
05-0245	1.0870
05-0248	1.1474
05-0251	.8793
05-0253	.9465
05-0254	1.0036
05-0255	.9844
05-0256	1.2091
05-0257	.9582
05-0258	.9892
* 05-0260	.9916
05-0261	1.0582
05-0262	1.1009
05-0263	1.0583
05-0264	1.1435
05-0266	1.0458
05-0267	1.1399
05-0268	1.1927
05-0269	1.0928
05-0270	1.0821
05-0272	1.0783
* 05-0273	.8927
* 05-0274	.9532
* 05-0275	.8918
05-0276	.9729
05-0277	1.0113
05-0278	1.0725
05-0279	.9703
05-0280	1.1014
05-0281	1.1742
05-0282	1.0434
05-0283	1.0971
* 05-0284	1.0275
* 05-0285	.9818
05-0286	1.0108
05-0289	1.1077
05-0290	.9776
05-0291	1.1263
05-0292	1.1311
* 05-0293	.9192
05-0295	1.0285
05-0296	1.1007
05-0298	.9560

PROVIDER NUMBER	CASE MIX INDEX
05-0299	1.0735
05-0300	1.1298
05-0301	1.0586
05-0302	1.1442
05-0303	1.0700
05-0305	1.0989
05-0307	1.0852
05-0308	1.1922
05-0309	1.0678
05-0310	1.0596
05-0312	1.1227
05-0313	.9923
* 05-0314	.9753
05-0315	1.0882
05-0317	1.0984
05-0318	.8862
05-0319	.9726
05-0320	1.0348
* 05-0322	1.1381
05-0323	1.0705
05-0324	1.1126
05-0325	1.0766
05-0326	1.0763
05-0327	1.1379
05-0328	1.0433
05-0329	.9231
05-0331	1.1220
* 05-0333	.9669
05-0334	1.1080
05-0335	.9975
05-0336	1.1107
05-0337	1.1016
05-0342	1.0352
05-0343	1.0500
05-0345	.9503
05-0348	1.0730
* 05-0349	.9562
05-0350	1.1807
05-0351	1.0815
05-0352	1.0546
05-0353	1.1031
* 05-0355	.9078
05-0357	1.1089
05-0359	1.0792
05-0360	1.0767
* 05-0361	.9867
05-0362	1.1200
05-0363	1.0186
05-0366	1.0584
05-0367	1.1085

PROVIDER NUMBER	CASE MIX INDEX
05-0368	1.0107
05-0369	1.0912
05-0371	1.0653
05-0372	1.0541
05-0373	1.0012
05-0375	1.0311
05-0376	1.0137
05-0377	.9907
05-0378	.9926
05-0379	.9518
05-0380	1.2889
05-0381	.9380
05-0382	1.0376
* 05-0383	1.1250
05-0385	1.0993
05-0387	.8981
05-0388	.9952
05-0390	1.0616
05-0391	1.0709
* 05-0392	.8399
05-0393	1.0531
05-0394	1.0846
05-0395	.9552
05-0396	1.2081
* 05-0397	.9978
05-0400	1.1283
05-0401	1.1014
05-0403	.9771
05-0404	1.0778
05-0405	1.0504
* 05-0406	.8711
05-0407	1.1328
05-0410	.9344
05-0411	1.0912
05-0413	1.1422
05-0414	.9633
* 05-0415	.9389
* 05-0416	1.0857
05-0417	1.0566
05-0418	1.0979
05-0419	1.0122
05-0420	1.0520
05-0421	1.1279
05-0423	.9584
05-0424	1.0862
05-0425	1.1030
05-0426	1.0332
* 05-0427	.9510
* 05-0428	.9424
* 05-0429	.9406

PROVIDER NUMBER	CASE MIX INDEX
05-0430	.9004
* 05-0431	1.0235
05-0432	1.1696
* 05-0433	.8973
05-0434	1.0507
05-0435	1.0889
05-0436	.9550
05-0438	1.1464
05-0440	1.0273
05-0441	1.3670
05-0442	1.0084
* 05-0443	.8811
05-0444	1.0651
05-0446	.9367
05-0447	1.0182
05-0448	.9638
05-0449	.9852
* 05-0450	.9135
* 05-0451	.9219
05-0454	1.3758
05-0455	1.1145
05-0456	1.1351
05-0457	1.1980
05-0458	1.0651
05-0459	1.0883
05-0464	1.2063
05-0467	1.1166
05-0468	.9893
05-0469	.9773
05-0470	1.0117
05-0471	1.1025
05-0473	1.0825
05-0476	.9565
05-0477	.9771
05-0478	1.0818
05-0481	1.0233
* 05-0482	.9323
05-0483	1.0209
05-0485	1.0870
05-0486	1.1087
* 05-0487	1.0801
05-0488	1.1072
05-0489	.9734
05-0491	1.0349
05-0492	1.1737
05-0494	.9604
05-0496	1.1867
* 05-0497	.8447
05-0498	1.0463
* 05-0500	.8565

PROVIDER NUMBER	CASE MIX INDEX
05-0502	1.3153
05-0503	1.0598
05-0506	1.1033
05-0510	1.0360
05-0512	1.0835
* 05-0513	.6051
05-0515	1.1152
05-0516	1.1152
05-0517	1.0380
* 05-0521	.7630
05-0522	1.0828
05-0523	1.0154
* 05-0525	.8705
05-0526	1.0795
05-0527	.9795
05-0528	1.0444
* 05-0530	.9808
05-0531	.9648
05-0534	.9087
05-0535	1.0652
05-0537	1.2116
05-0539	1.0444
05-0540	.9018
05-0541	1.2708
05-0542	1.0126
05-0543	1.1597
05-0544	1.0349
05-0549	1.1777
05-0550	.9311
05-0551	1.1195
05-0552	.9229
05-0557	1.1092
05-0559	1.0808
05-0560	1.0865
05-0561	1.0326
05-0562	.8976
05-0564	1.0579
05-0565	1.0056
* 05-0566	.9527
05-0567	1.0019
05-0568	1.0034
05-0569	1.0953
05-0570	1.1743
05-0571	1.0619
05-0573	1.1165
05-0575	1.0466
05-0576	1.1037
05-0577	1.0757
05-0578	.9951
05-0579	.9730

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 4

PROVIDER NUMBER	CASE MIX INDEX
05-0580	1.0407
05-0581	1.0587
05-0582	1.2832
05-0584	1.0659
05-0585	1.0746
05-0586	1.0962
05-0587	1.0209
05-0588	1.0730
05-0589	1.0100
05-0590	1.0888
05-0591	1.0349
05-0592	1.0240
05-0593	1.0135
05-0594	1.0578
* 05-0595	1.0550
05-0597	.9991
05-0598	.9759
05-0599	1.1840
05-0601	1.0236
05-0602	1.1318
05-0603	1.0694
05-0604	1.0808
* 05-0605	.9702
* 05-0606	1.1507
05-0607	.9494
05-0608	1.1844
05-0609	1.1681
* 05-0610	.9382
05-0615	1.1514
05-0616	.9886
05-0617	.9037
* 05-0618	.9848
05-0619	1.0745
05-0622	1.0244
05-0623	.8703
05-0624	1.0340
05-0625	1.1915
05-0626	.8177
05-0627	.8239
05-0628	.8183
* 05-0629	.8568
05-0630	1.1223
* 05-0631	.8194
* 05-0632	1.1394
05-0633	1.1203
05-0635	1.0908
05-0636	1.0441
05-0637	1.0448
* 05-0638	1.0921
* 05-0640	.5021
05-0641	1.0741
* 05-0642	.8194
05-0644	1.1762
* 05-0645	1.2401
* 05-0646	.8148
* 05-0648	.9371
* 05-0650	.7355
06-0001	.9766
06-0003	1.0307
06-0004	.9264
06-0005	1.0385
06-0006	1.0115
* 06-0007	1.0706
06-0008	.9748
06-0009	1.0370
06-0010	1.0874
06-0011	1.0180
06-0012	1.0365
06-0013	.9855
06-0014	1.1360
06-0015	1.0779
06-0016	.9070
06-0017	1.0158
06-0018	.9065
06-0019	1.0646
06-0020	1.1525
06-0022	.9652
06-0023	.9920
06-0024	1.2706
06-0025	.9073
06-0026	1.0283
06-0027	1.0882
06-0028	1.0918
* 06-0029	.9002
06-0030	1.0277
06-0031	1.1204
06-0032	1.0281
06-0033	1.0823
06-0034	1.0785
06-0035	1.0038
06-0036	1.1184
06-0037	.9545
* 06-0038	.9473
06-0039	.9093
* 06-0041	.8816
* 06-0042	.9578
* 06-0043	.8800
06-0044	.9595
06-0045	.9538
* 06-0046	1.0590
* 06-0047	.9735
* 06-0049	1.0569
06-0050	.9110
06-0051	1.0440
* 06-0052	.8830
* 06-0053	.9271
06-0054	.9205
* 06-0055	.9238
* 06-0056	1.0222
* 06-0057	1.2874
* 06-0058	.9523
* 06-0059	1.0491
* 06-0060	.9717
06-0061	.9398
* 06-0062	1.0009
* 06-0063	.9830
06-0064	.9851
06-0065	.9874
* 06-0066	.9155
* 06-0067	.9246
* 06-0068	1.0324
* 06-0069	.9111
* 06-0070	.9513
06-0071	1.0276
* 06-0072	.9264
* 06-0073	.6120
* 06-0074	.9640
06-0075	1.0738
06-0076	1.0534
* 06-0077	.8436
* 06-0083	.8367
* 06-0085	.8034
06-0087	1.0867
* 06-0088	.9126
* 06-0090	1.0171
* 06-0092	.8104
* 06-0093	1.0408
* 06-0096	1.2619
07-0001	1.2649
07-0002	1.1663
07-0003	1.0895
07-0004	1.0698
07-0005	1.0958
07-0006	1.1094
07-0007	1.1398
07-0008	.9974
07-0009	1.0739
07-0010	1.1312
07-0011	1.1014
07-0012	1.1253
07-0013	1.0861
07-0014	1.0478
07-0015	1.0927
07-0016	1.1340
07-0017	1.0725
07-0018	1.0242
07-0019	1.0727
07-0020	1.1070
07-0021	1.0243
07-0022	1.1782
07-0023	1.0325
07-0024	1.0418
07-0025	1.2112
07-0026	1.0548
07-0027	1.1202
07-0028	1.1668
07-0029	.9829
07-0030	1.0638
07-0031	1.0532
07-0033	1.1269
07-0034	1.0543
07-0035	1.1471
07-0036	1.1461
* 07-0038	1.1131
08-0001	1.1347
08-0002	.9799
08-0003	1.0952
08-0004	1.1281
08-0005	.9634
08-0006	1.0334
08-0007	.9906
09-0001	1.1448
09-0002	1.1164
09-0003	1.0848
09-0004	1.1598
09-0005	1.0715
09-0006	1.0445
09-0007	.9484
09-0008	1.1052
09-0009	1.0053
* 09-0010	1.0990
09-0011	1.2288
10-0001	1.0682
10-0002	1.0739
10-0004	.8855
10-0005	.9529
10-0006	1.0106
10-0007	1.1365
10-0008	1.0724
10-0009	1.0806
10-0010	1.0935
10-0011	.8948
10-0012	1.0005
10-0013	.9917
10-0014	.9613
10-0015	1.0740
10-0016	1.0385
10-0017	1.0732
10-0018	1.1244
10-0019	1.0590
10-0020	.9692
10-0021	1.0124
10-0022	1.2099
10-0023	.9897
10-0024	1.0638
10-0025	1.1482
10-0026	1.0235
10-0027	.8842
10-0028	.9967
10-0029	1.0272
10-0030	.9146
10-0031	.8162
10-0032	1.1125
10-0033	1.0085
10-0034	1.1234
10-0035	1.0316
10-0036	.9988
10-0038	1.0969
10-0039	1.0944
10-0040	1.1597
10-0042	.9668
10-0043	1.0705
10-0044	1.0579
10-0045	1.0774
10-0046	.9336
10-0047	1.0081
10-0048	.8103
10-0049	1.1048
10-0050	.9604
10-0051	.9206
10-0052	.9763
10-0053	1.0482
10-0054	.9049
10-0055	.9604
10-0056	.9161
10-0057	.9799
10-0059	1.0683
10-0060	1.2135
10-0061	1.1032
10-0062	1.1738

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 5

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
10-0063	1.1144	10-0126	1.0640	10-0185	.9440	* 10-0245	1.1042	11-0044	.9777
10-0065	1.0366	10-0127	1.1200	10-0186	1.1082	10-0246	1.0694	11-0045	.8755
10-0067	1.0551	10-0128	1.6495	10-0187	1.0223	* 10-0247	.8934	11-0046	1.0003
10-0068	1.0204	10-0129	1.0563	10-0189	1.0065	10-0248	1.0608	11-0047	.9205
10-0069	.9949	10-0130	1.0389	10-0191	1.0607	10-0249	1.0087	11-0048	.9806
10-0070	1.1454	10-0131	1.0484	10-0193	.8154	10-0251	.9416	11-0049	.8592
10-0071	.9462	10-0132	1.0491	10-0194	.9307	10-0252	.9774	* 11-0050	.9055
10-0072	.9720	* 10-0133	.7304	10-0195	1.0393	10-0253	1.1254	11-0051	.8806
10-0073	1.1166	10-0134	.8981	10-0196	1.0745	10-0254	1.0055	11-0052	.8946
10-0074	.9340	10-0135	1.0937	10-0199	1.0670	10-0255	.9890	11-0054	1.0631
10-0075	1.0288	10-0137	.9508	10-0200	1.1049	10-0256	1.0832	11-0055	.9383
10-0076	.9971	10-0138	.8588	* 10-0201	1.0267	11-0001	1.0519	11-0056	.9213
10-0077	.9529	10-0139	.9637	10-0203	1.0578	11-0002	.9640	11-0059	.9808
10-0078	.8304	10-0140	.9484	10-0204	1.1522	11-0003	.9917	11-0061	.9265
10-0079	.9714	10-0142	.9485	10-0206	1.0562	11-0004	1.0138	11-0062	.9056
10-0080	1.1434	10-0143	1.0168	10-0207	1.0625	11-0005	.9454	11-0063	.9116
10-0081	.9140	10-0144	1.0074	10-0208	1.0151	11-0006	1.0901	11-0064	1.0884
10-0082	1.0811	10-0145	.9808	10-0209	1.0666	11-0007	1.1442	11-0065	.8885
10-0083	1.0445	10-0146	.9618	10-0210	1.0601	11-0008	.9432	11-0066	1.1061
10-0084	.9633	10-0147	.8898	10-0211	.9674	11-0009	.9493	11-0067	.9104
10-0085	1.0009	10-0149	1.1224	10-0212	1.0909	11-0010	1.3363	11-0069	1.0165
10-0086	1.0531	10-0150	.8953	10-0213	1.0958	11-0011	.9824	11-0070	.8622
10-0087	1.1042	10-0151	1.0853	10-0214	.9939	11-0013	.9816	11-0071	.9172
10-0088	1.1095	10-0152	.9622	10-0217	1.0519	11-0014	.8929	11-0072	.9016
10-0089	1.0600	10-0153	.8243	10-0218	.9841	11-0015	1.0211	11-0073	.9176
10-0090	.9528	10-0154	1.0969	10-0219	1.0176	11-0016	1.0565	11-0074	1.0833
10-0092	1.0443	10-0156	.8921	10-0220	1.1208	11-0017	.9680	11-0075	.9963
10-0093	.9963	10-0157	1.0616	10-0221	1.2535	11-0018	.9423	11-0076	1.1442
10-0096	1.0257	10-0159	.8523	10-0222	.9690	11-0020	.9665	11-0077	.8655
10-0099	.9673	10-0160	.9428	10-0223	1.0461	11-0023	.8969	11-0078	1.1304
10-0100	1.0049	10-0161	1.0513	10-0224	1.0023	11-0024	1.0558	11-0079	1.0339
10-0102	.8946	10-0162	1.0735	10-0225	1.0309	11-0025	1.0642	11-0080	.9843
10-0103	.9386	10-0164	.9035	10-0226	1.0312	11-0026	.9091	11-0081	.9231
10-0105	1.0643	10-0165	.9334	* 10-0227	.8552	11-0027	.9145	11-0082	1.2646
10-0106	.9344	10-0166	.9976	10-0228	.9461	11-0028	1.1037	11-0083	1.0904
10-0107	.9687	10-0167	.9926	10-0229	1.0374	11-0029	.9616	11-0084	.9123
10-0108	.9320	10-0168	1.1004	10-0230	.9871	11-0030	.9779	11-0085	1.0407
10-0109	.9931	10-0169	1.1685	10-0231	1.2066	11-0031	1.0098	11-0086	.9502
10-0110	1.0207	10-0170	1.0858	10-0232	.9872	11-0032	.9862	11-0087	.9528
10-0112	.9481	10-0172	1.0283	10-0234	1.0546	11-0033	1.0009	* 11-0088	.8658
10-0113	1.2969	10-0173	1.0432	10-0235	1.0059	11-0034	1.0439	11-0089	.9022
10-0114	1.0162	10-0174	1.0298	10-0236	1.0693	11-0035	1.0316	11-0091	1.0836
10-0115	1.0214	10-0175	.8913	10-0237	1.2402	11-0036	1.2982	11-0092	.9700
10-0117	1.0215	10-0176	1.1192	10-0238	1.0036	11-0037	.9232	11-0093	.9375
10-0118	.8933	10-0177	1.0443	10-0239	1.0142	11-0038	1.0123	11-0094	.8218
10-0120	.9384	10-0179	1.1436	10-0240	.5811	11-0039	1.0365	11-0095	1.0566
10-0121	.8768	10-0180	1.1645	10-0241	.8441	11-0040	.9155	11-0096	.9680
10-0122	.8883	10-0181	.8386	10-0242	.9964	11-0041	.9430	11-0097	.8496
10-0124	.9826	* 10-0182	.7765	10-0243	1.0448	11-0042	.9496	11-0098	.8959
10-0125	.9702	10-0183	.9580	10-0244	1.0602	11-0043	1.0475	11-0099	.9589

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3B HOSPITAL CASE MIX INDEXES Page 6

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
11-0100	1.0060	11-0165	1.1029	13-0002	1.0657	14-0008	1.0198	14-0066	.9968
11-0101	.9142	11-0166	1.0236	13-0003	1.0849	14-0009	.9615	14-0067	1.0883
11-0102	1.0011	11-0168	.9848	13-0005	.9590	14-0010	1.0866	14-0068	1.0140
11-0104	1.0013	11-0169	.9502	13-0006	1.2374	14-0011	.9835	14-0069	.9858
11-0105	1.0075	11-0170	.8359	13-0007	1.1374	14-0012	.9508	14-0070	1.0107
11-0107	1.2246	11-0171	1.0729	* 13-0008	1.1162	14-0013	1.0468	14-0072	.9986
11-0108	.9378	11-0172	1.0751	13-0009	.9710	14-0014	.9741	14-0074	1.0464
11-0109	.9521	11-0174	.8839	13-0010	1.0040	14-0015	1.0298	14-0075	1.1733
11-0111	.9188	11-0175	1.0178	13-0011	1.0358	14-0016	1.0195	* 14-0076	1.0612
11-0112	.5127	11-0176	.8922	* 13-0012	.9443	14-0017	1.0693	14-0077	.9727
11-0113	1.0123	11-0177	1.0456	13-0013	1.0266	14-0018	1.1214	14-0079	1.0622
11-0114	.9408	11-0178	.6516	13-0014	1.0386	14-0019	.8946	14-0080	1.1877
11-0115	1.0540	11-0179	1.0162	13-0015	.9223	14-0023	.9319	14-0081	1.0367
11-0117	.5752	11-0181	1.0134	13-0016	1.0009	14-0024	.8915	14-0082	1.0584
11-0118	.9134	11-0182	.9651	* 13-0017	.9126	14-0025	1.0586	14-0083	1.0592
11-0120	.5052	11-0183	1.0087	13-0018	1.0991	14-0026	1.0121	14-0084	1.0529
11-0121	.9130	11-0184	1.0163	13-0019	1.0681	14-0027	1.0208	14-0085	1.0529
11-0122	1.0306	11-0185	.9735	* 13-0021	.9488	14-0029	1.0745	14-0086	1.0597
11-0123	.9745	11-0186	.9589	13-0022	.9851	14-0030	1.0324	14-0087	1.0682
11-0124	.9226	11-0187	.9004	13-0024	1.0057	14-0031	1.0378	14-0088	1.1969
11-0125	.5551	11-0188	1.0465	13-0025	.9795	14-0032	.9316	14-0089	.9670
11-0127	.8652	11-0189	.9092	13-0026	1.1308	14-0033	1.0267	14-0090	1.0303
11-0128	.9626	11-0190	.8736	13-0027	.9108	14-0034	.9350	14-0091	1.1295
11-0129	1.1402	11-0191	1.0976	13-0028	1.0524	14-0035	1.0017	14-0093	.9552
11-0130	.5027	11-0192	1.0347	13-0029	.9766	14-0036	.9385	14-0094	1.0678
* 11-0131	.8366	11-0193	.9768	* 13-0030	.8698	14-0037	.9191	14-0095	1.0778
11-0132	.9492	11-0194	.9190	* 13-0031	.8937	14-0038	1.0347	14-0097	.9668
11-0133	1.0048	11-0195	1.0051	* 13-0032	.5382	14-0039	.9487	14-0098	1.0323
11-0134	.8720	* 11-0196	1.3425	13-0034	.9412	14-0040	1.0124	14-0099	.9979
11-0135	.9242	12-0001	1.1640	13-0035	.9567	14-0041	1.0290	14-0100	1.0324
* 11-0136	1.1293	12-0002	1.1302	13-0036	1.0433	14-0042	.9170	14-0101	.9887
11-0140	.8943	12-0003	1.0201	13-0037	.8699	14-0043	.9866	14-0102	.9306
11-0141	.5208	12-0004	.9541	* 13-0038	.9225	* 14-0044	.9107	14-0103	1.0306
11-0142	.8852	12-0005	1.0775	* 13-0039	1.2372	14-0045	.9940	14-0104	.9278
11-0143	1.0519	12-0006	1.0852	* 13-0040	.5952	14-0046	1.0195	14-0105	1.0717
11-0144	.9968	12-0007	1.0316	* 13-0041	.8561	14-0047	1.0167	14-0107	.9960
11-0146	.8830	* 12-0008	.8456	13-0042	.9667	14-0048	1.0089	14-0108	1.0141
11-0149	.9328	* 12-0009	.9751	* 13-0044	.9363	14-0049	1.0803	14-0109	.9597
11-0150	1.0311	12-0010	1.2607	13-0045	.9561	14-0051	1.0160	14-0110	.9663
11-0151	1.0358	12-0011	1.0968	* 13-0048	.5749	14-0052	.8966	14-0111	1.0219
11-0152	.9408	* 12-0012	1.0962	13-0049	1.0238	14-0053	1.1470	14-0112	.9595
11-0153	.8838	12-0014	1.0788	* 13-0050	.8341	14-0054	1.0592	14-0113	1.0894
11-0154	.5238	* 12-0015	.7600	13-0051	.8803	14-0055	.9848	14-0114	1.0628
11-0155	.9615	* 12-0016	.5687	* 13-0053	.8164	14-0058	1.0065	14-0115	.9881
* 11-0156	.9015	* 12-0018	1.0077	* 13-0054	.8738	14-0059	.9643	14-0116	1.0492
11-0157	.5318	12-0019	.9944	14-0001	1.0277	14-0061	.9687	14-0117	1.0594
11-0158	.9313	12-0020	1.0181	14-0002	1.0154	14-0062	1.0376	14-0118	1.1804
11-0161	1.1617	* 12-0021	1.0288	14-0004	.9768	14-0063	1.0669	14-0119	1.2373
11-0162	1.0685	12-0022	1.2126	14-0005	.5269	14-0064	1.1127	14-0120	1.0277
11-0164	.9875	13-0001	1.0328	14-0007	1.0623	14-0065	1.0496	14-0121	1.0368

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 7

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
14-0122	1.0336	14-0174	1.0244	14-0235	.9163	15-0018	1.0779	15-0073	.9974
14-0123	1.0282	14-0176	.9796	* 14-0236	1.0097	15-0019	.9761	15-0074	1.1167
14-0124	.9125	14-0177	1.0729	14-0239	1.0830	15-0020	.9428	15-0075	1.0620
14-0125	1.0030	14-0178	.9726	14-0240	.9743	15-0021	1.1973	15-0076	1.0254
14-0126	1.1078	14-0179	1.0392	* 14-0241	.8370	15-0022	.9621	15-0077	1.0728
14-0127	1.0273	14-0180	1.0997	14-0242	1.0811	15-0023	1.0327	15-0078	.9737
14-0128	.9813	14-0181	1.0294	14-0243	1.0343	15-0024	1.0790	15-0079	.9515
14-0129	.9581	14-0182	1.0989	14-0245	.9070	15-0025	1.0217	15-0081	.9309
14-0130	1.0423	14-0184	1.0193	14-0246	.9258	15-0026	.9829	15-0082	1.1202
14-0131	1.0872	14-0185	1.0796	14-0247	.9483	15-0027	.9562	15-0083	1.0475
14-0132	1.1623	14-0186	1.0022	14-0248	1.0350	15-0029	1.0923	15-0084	1.2278
14-0133	1.0902	14-0187	1.0205	14-0250	1.1370	15-0030	.9730	15-0085	.9222
14-0134	.9524	14-0188	.8778	14-0251	.9657	15-0031	.9514	15-0086	.9950
14-0135	1.0306	14-0189	1.0883	14-0252	1.0885	15-0032	1.2476	15-0088	.9758
14-0136	.9395	14-0190	.9395	14-0253	1.0041	15-0033	1.0836	15-0089	1.1158
14-0137	.9600	14-0191	1.0881	* 14-0255	.7836	15-0034	.9923	15-0090	.9765
14-0138	.8954	14-0192	1.0466	14-0257	.9008	15-0035	1.0681	15-0091	.9802
14-0139	.9609	14-0193	.9301	14-0258	1.0638	15-0036	.8788	15-0092	.9807
14-0140	1.0022	14-0197	1.0797	14-0261	1.1199	15-0037	1.0385	15-0094	.9333
14-0141	.9896	14-0199	.9740	14-0271	.9059	15-0038	1.0181	15-0095	.9943
14-0142	.9786	14-0200	1.0789	14-0273	.8767	15-0039	1.0479	15-0096	.8796
14-0143	.9780	* 14-0201	.9595	14-0275	1.0002	15-0042	1.0232	15-0097	.9699
14-0144	.9931	14-0202	1.0490	14-0276	1.3641	15-0043	1.0047	15-0098	.9801
14-0145	1.0337	14-0203	1.0754	14-0280	1.0668	15-0044	1.0204	15-0099	1.0215
14-0146	.9216	14-0204	1.0753	14-0281	1.1752	15-0045	1.0154	15-0100	1.0903
14-0147	.9855	14-0205	1.0238	14-0285	1.0664	15-0046	1.0829	15-0101	.9390
14-0148	1.0767	14-0206	.9232	14-0286	1.0756	15-0047	1.0160	15-0102	.9763
14-0150	1.1012	14-0207	1.0589	14-0288	1.0559	15-0048	1.0461	15-0103	.9166
14-0151	.9463	14-0208	1.1441	14-0289	1.0571	15-0049	.9429	15-0104	1.0193
14-0152	1.1137	14-0209	1.0960	14-0290	1.0453	15-0050	.9927	15-0105	1.0120
14-0153	1.0424	14-0210	.9720	14-0291	.9999	15-0051	1.0169	15-0106	.9096
14-0154	1.0703	14-0211	1.0875	14-0292	1.1100	15-0052	.8753	15-0109	1.0529
14-0155	.9720	14-0212	.9684	14-0293	.8747	15-0053	.9116	15-0110	.9597
14-0156	1.0435	14-0213	1.0751	* 14-0294	1.0786	15-0054	.9866	15-0111	.9880
14-0157	.9074	14-0215	1.0135	15-0001	.9564	15-0056	1.1972	15-0112	1.0499
14-0158	1.1130	* 14-0216	.7820	15-0002	1.0920	15-0057	.8407	15-0113	.9976
14-0159	.9561	14-0217	1.0471	15-0003	1.0777	15-0058	1.1102	15-0114	.9526
14-0160	1.0525	14-0218	.9678	15-0004	1.0839	15-0059	.9781	15-0115	.9627
14-0161	1.0470	14-0219	.9898	15-0005	1.0581	15-0060	.9536	15-0122	.9145
14-0162	1.0437	14-0220	.9876	15-0006	1.0462	15-0061	1.0629	15-0123	.9314
14-0163	.9480	14-0223	1.0668	15-0007	.9287	15-0062	.9157	15-0124	.9832
14-0164	1.0330	14-0224	1.0981	15-0008	1.1659	15-0063	1.0806	15-0125	1.0338
14-0165	.8155	14-0226	1.0135	15-0009	.9703	15-0064	.9821	15-0126	1.1981
14-0166	1.0201	14-0228	1.1015	15-0010	1.0147	15-0065	.9536	15-0127	.9988
14-0167	.9930	* 14-0229	.9464	15-0011	1.0328	15-0066	1.0205	15-0128	1.0406
14-0168	.9918	* 14-0230	1.0367	15-0012	1.1669	15-0067	1.0234	15-0129	1.0023
14-0170	.9867	14-0231	1.0343	15-0013	.9508	15-0069	.9804	15-0130	1.0826
14-0171	.9638	14-0232	.9209	15-0014	1.0265	15-0070	.9564	15-0132	1.1104
14-0172	1.0901	14-0233	1.1146	15-0015	.9955	15-0071	.9961	15-0133	1.0384
14-0173	1.0407	14-0234	.9709	15-0017	1.1603	15-0072	1.0550	15-0134	.9459

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PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
* 15-0135	.9007	16-0058	1.1575	16-0114	.9217	17-0019	1.0838	17-0077	.8956
16-0001	.8709	16-0059	1.0513	16-0115	.9608	17-0020	.9913	* 17-0079	.8607
16-0002	.9441	16-0060	.9737	16-0116	.9758	17-0021	.9021	17-0080	.8378
16-0003	.9332	16-0061	.8915	16-0117	1.1057	17-0022	.9968	17-0081	.9772
16-0004	1.0530	16-0062	.9512	16-0118	.9012	17-0023	.9711	* 17-0082	.9883
16-0005	.9311	* 16-0063	1.0559	16-0119	1.0276	17-0024	.9493	17-0084	.9362
16-0007	.8993	16-0064	1.0414	16-0120	.9099	17-0025	.9338	* 17-0085	.9806
16-0008	.9701	16-0065	.8879	16-0121	1.0462	17-0026	1.0273	17-0086	1.1570
16-0009	.9438	16-0066	.9823	16-0122	.9339	17-0027	.8861	17-0087	1.0730
16-0012	.9383	16-0067	1.0505	16-0123	1.0544	17-0030	.8896	17-0088	.8904
16-0013	1.1140	16-0068	.9216	16-0124	.9847	17-0031	.9888	* 17-0089	.9639
16-0014	.9151	16-0069	1.1521	16-0126	.9564	17-0032	.9338	* 17-0090	.9407
16-0016	1.0586	16-0070	.8766	16-0129	1.0416	17-0033	.9641	17-0091	.9707
16-0018	.9486	16-0071	.9612	16-0130	.9575	* 17-0034	.8950	17-0092	.9160
16-0020	.9144	16-0072	1.0014	16-0131	.9614	17-0035	.9429	17-0093	1.0174
16-0021	.9182	16-0073	.9424	* 16-0132	.8988	* 17-0036	.9685	17-0094	.9874
16-0023	1.0287	16-0074	.9539	16-0133	.9465	17-0037	1.1138	17-0095	.9817
16-0024	.9645	16-0075	.9192	16-0134	.9036	17-0038	.8767	* 17-0096	.8736
16-0025	1.1566	16-0076	.9317	16-0135	.9458	17-0039	.9387	17-0097	.9641
16-0026	.9562	16-0077	.8631	* 16-0136	.9803	17-0040	1.1560	17-0098	.9076
16-0027	1.0405	16-0079	1.0715	16-0138	1.0581	17-0041	.9614	* 17-0099	1.0587
16-0028	1.0014	16-0080	.9411	* 16-0139	.8507	17-0043	.9060	* 17-0100	.8790
16-0029	1.0760	16-0081	.9912	16-0140	.9611	17-0044	.8957	17-0101	.8871
16-0030	1.0370	16-0082	1.1875	* 16-0141	.9379	17-0045	.7839	17-0102	.9581
16-0031	.9211	16-0083	1.1702	* 16-0142	.9689	17-0046	.9319	17-0103	1.1044
16-0032	1.0155	16-0085	1.0772	16-0143	.9327	17-0049	.9345	17-0104	.9702
16-0033	1.0315	16-0086	.8919	16-0145	1.0121	* 17-0050	1.0050	17-0105	.9291
16-0034	.9966	16-0088	.9259	16-0146	1.0205	17-0051	1.0296	17-0106	.9148
16-0035	.9234	16-0089	.9876	16-0147	1.0292	17-0052	.9623	* 17-0108	.8051
16-0036	.9854	16-0090	.9605	16-0151	1.0654	17-0053	.9401	17-0109	.9384
16-0037	.9965	16-0091	1.0612	16-0152	.9475	17-0054	.9468	17-0110	.8804
16-0038	1.0089	16-0092	.9327	16-0153	1.0515	17-0055	.8655	17-0112	.8976
16-0039	.9037	16-0093	.8604	17-0001	.9209	* 17-0056	.9463	17-0113	.9585
16-0040	1.0277	16-0094	.9919	17-0002	.9120	17-0057	.9217	17-0114	.9562
16-0041	.9537	* 16-0095	1.0695	17-0003	1.0064	17-0058	.9632	17-0115	.9775
16-0042	.9584	16-0097	.9817	17-0004	.9135	17-0060	.9343	17-0116	.9307
16-0044	.9758	16-0098	.9321	17-0005	.8775	17-0061	.9587	* 17-0117	.8014
16-0045	1.1178	16-0099	.9470	17-0006	1.0041	* 17-0062	.8347	* 17-0119	.8537
16-0046	1.0272	16-0101	1.0357	17-0007	1.0314	* 17-0063	.8519	17-0120	.9813
16-0047	1.0414	16-0102	1.0704	17-0008	.9434	* 17-0064	.9365	* 17-0121	.9287
16-0048	.8794	16-0103	.8999	17-0009	1.0711	17-0066	.8725	17-0122	1.1276
16-0049	.8741	16-0104	1.0503	17-0010	.9820	17-0067	.9339	17-0123	1.0627
16-0050	.9462	16-0106	.9766	17-0011	1.0016	17-0068	.9690	17-0124	.8710
16-0051	.8637	16-0107	.9454	17-0012	1.1158	* 17-0069	.8835	17-0125	.9324
16-0052	1.0065	16-0108	1.0012	17-0013	.9495	17-0070	.9707	17-0126	.8839
16-0053	1.0201	* 16-0109	.9942	17-0014	.9052	17-0072	.9159	17-0128	.9710
16-0054	.9344	16-0110	1.1255	17-0015	.9207	17-0073	1.0027	* 17-0130	.8772
16-0055	.9558	* 16-0111	.9188	17-0016	1.2296	17-0074	1.0609	17-0131	.9727
16-0056	.9519	16-0112	.9775	17-0017	1.0086	* 17-0075	.9490	17-0133	1.0174
16-0057	1.0402	16-0113	1.0005	17-0018	.9673	17-0076	.9065	17-0134	.9429

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
17-0137	1.0300	18-0026	.9524	18-0053	1.0960	19-0019	1.0792	19-0106	.9494
17-0138	.9568	18-0027	1.0494	18-0054	.9676	19-0020	1.0083	19-0109	.9969
* 17-0139	.9025	18-0028	.9286	18-0055	1.0038	19-0023	.9024	19-0110	.9550
17-0140	.9322	18-0029	.9826	18-0059	.9301	19-0025	1.0134	19-0111	1.0267
17-0142	.9367	18-0030	.9566	18-0100	1.0877	19-0026	1.0334	19-0112	1.0251
17-0143	1.0395	18-0031	.9172	18-0101	.9670	19-0027	1.0244	19-0113	1.0366
17-0144	1.0269	18-0032	.9468	18-0102	1.0800	19-0029	.9529	19-0114	.9081
17-0145	1.0038	18-0033	.9249	18-0103	1.1573	19-0033	.8821	19-0115	1.0686
17-0146	1.0101	18-0034	1.0210	18-0104	1.0384	19-0034	.8966	19-0116	.9871
17-0147	.9919	18-0035	1.0821	18-0105	.9566	19-0035	1.0852	19-0117	.9891
17-0148	1.0253	18-0036	.9155	18-0106	.9495	19-0036	1.2043	19-0118	.9556
17-0150	.8949	18-0037	1.0433	18-0108	.8972	* 19-0037	.8452	19-0119	.9256
17-0151	.9642	18-0038	1.0249	18-0112	.9275	19-0039	1.0430	19-0120	.9692
17-0152	.9458	18-0040	1.2040	18-0114	.8872	19-0040	.9363	19-0122	.9477
* 17-0155	.9979	18-0041	1.0190	18-0115	.9391	19-0041	1.1263	19-0124	1.0370
17-0160	.8553	18-0042	.9739	18-0116	1.0192	19-0043	.9607	19-0125	1.0734
17-0164	.9367	18-0043	.9556	18-0117	.9116	19-0044	.9607	19-0127	1.0161
* 17-0166	1.1136	18-0044	.9701	18-0118	.9479	19-0045	1.0243	* 19-0128	1.1076
* 17-0168	.9231	18-0045	.9771	18-0120	.8757	19-0046	1.1456	19-0130	.8181
* 17-0170	.9325	18-0046	.9832	* 18-0121	.8679	19-0047	.9124	19-0131	.8982
17-0171	.9876	18-0047	.9707	18-0122	.8533	19-0048	1.0231	19-0132	.9495
17-0172	1.0079	18-0048	1.0651	18-0123	1.0630	19-0049	.9818	19-0133	.8491
* 17-0173	.8992	18-0049	1.0335	18-0124	.9706	19-0050	.8941	19-0134	.8713
* 17-0174	.8474	18-0050	.9865	18-0125	.9849	19-0053	.9793	19-0135	1.1397
17-0175	1.0205	18-0051	1.0648	18-0126	.9759	19-0054	1.0709	19-0136	.9008
17-0176	1.0583	18-0053	.9462	18-0127	1.0378	19-0058	.9625	19-0137	.8813
* 17-0177	.9725	18-0054	.9867	18-0128	1.0156	19-0059	.9436	19-0138	.6082
18-0001	1.0709	18-0055	.9061	18-0129	.9727	19-0060	.9820	19-0139	.9407
18-0002	.9511	18-0056	1.0333	18-0130	1.0472	19-0064	1.0936	19-0140	.9449
18-0004	1.0031	18-0058	.9297	18-0132	1.0321	19-0065	1.1627	19-0141	.8396
18-0005	1.0411	18-0059	.9138	18-0133	1.0776	19-0067	.9807	19-0142	.8827
18-0006	.8580	18-0060	.9834	* 18-0134	.9591	19-0071	.9339	19-0144	1.0087
18-0007	1.0447	18-0062	.9355	19-0001	.8346	19-0073	.8813	19-0145	.9399
18-0008	1.0612	18-0063	.9572	19-0002	1.2784	19-0075	1.0185	19-0146	1.1908
18-0009	.9809	18-0064	1.0531	19-0003	.9550	19-0077	.8931	19-0147	.9493
18-0010	1.0681	18-0065	.8582	19-0004	1.0482	19-0078	.9861	19-0148	.8992
18-0011	.9270	18-0066	.9475	19-0005	1.0586	19-0079	.9848	19-0149	.9251
18-0012	1.0211	18-0067	1.2336	19-0006	1.0253	19-0081	.9389	19-0151	.9897
18-0013	1.0650	18-0069	1.0367	19-0007	.8952	19-0083	.8574	* 19-0152	.9584
18-0014	1.0480	18-0070	.9486	19-0008	1.0114	19-0086	1.0223	19-0155	.8901
18-0015	1.0048	18-0072	1.0455	19-0009	1.1204	19-0088	.9180	19-0156	.8743
18-0016	1.0495	18-0075	.8683	19-0010	.9805	19-0089	.9412	19-0157	.9419
18-0017	1.0015	18-0078	.9242	19-0011	.9175	19-0090	.8945	19-0158	.9832
18-0018	1.0143	18-0079	.9287	19-0012	.9089	19-0092	.9731	19-0160	.9594
18-0019	.9566	18-0080	1.0033	19-0013	1.0048	19-0095	.8903	19-0161	.9101
18-0020	.9264	18-0081	1.0882	19-0014	.9054	19-0098	1.1622	19-0162	1.0585
18-0021	.9814	18-0085	1.0867	19-0015	.9235	19-0099	.9808	* 19-0163	.8486
18-0022	.8962	18-0087	1.0065	19-0016	.9625	19-0101	.9144	19-0164	.8771
18-0024	.9564	18-0088	1.1082	19-0017	.9791	19-0102	1.1039	19-0165	.8665
18-0025	1.0485	18-0092	.9451	19-0018	1.0120	19-0103	.8790	19-0166	.8529

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 10

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
19-0167	.9391	20-0040	.9538	21-0037	1.0339	22-0040	1.0443	22-0099	.9926
19-0168	1.1499	20-0041	.9559	21-0038	1.0228	22-0041	1.0764	22-0100	1.1699
19-0169	.9533	20-0043	1.0265	21-0039	1.0652	22-0042	1.0339	22-0101	1.1010
19-0170	.8832	20-0044	1.0559	21-0040	1.1181	22-0045	1.0373	* 22-0102	.9951
* 19-0172	.9060	20-0046	1.0178	21-0041	1.1473	22-0046	1.1115	22-0104	1.0761
19-0173	1.0689	20-0047	1.0097	21-0042	1.1731	22-0048	1.0542	22-0105	1.0542
19-0175	1.0057	* 20-0049	.9825	21-0043	1.1080	22-0049	1.0116	22-0106	1.0614
19-0176	1.1424	20-0050	1.0132	21-0044	.9528	22-0050	.9545	22-0107	1.0067
19-0177	.9806	20-0051	.9798	21-0045	1.1417	22-0051	1.0834	22-0108	1.0809
19-0178	.8678	20-0052	1.0005	21-0046	.9388	22-0052	1.0779	22-0110	1.4383
19-0179	.9197	20-0055	.9629	21-0047	.8841	22-0053	1.0180	22-0111	1.0552
19-0180	.9477	* 20-0056	.6173	21-0048	1.0411	22-0054	1.0932	22-0114	1.0488
19-0182	.9571	20-0062	.9783	21-0049	1.0495	22-0055	1.0671	22-0115	1.0770
19-0183	.8654	20-0063	1.0755	21-0051	1.1342	22-0057	1.0101	22-0116	1.2472
19-0184	.8515	* 20-0065	.8455	21-0054	1.0338	22-0058	.9629	22-0117	1.0851
19-0185	1.0029	20-0066	1.0966	21-0055	1.0622	22-0060	1.1056	22-0118	1.3412
19-0186	.9097	21-0001	1.1188	21-0056	1.1138	22-0061	1.0457	22-0119	1.1389
19-0187	.8960	21-0002	1.3013	21-0057	1.0593	22-0062	.9252	22-0120	1.0075
19-0190	.8587	21-0003	1.1090	22-0001	1.0446	22-0063	1.0140	22-0121	.9789
20-0001	1.1242	21-0004	1.1257	22-0002	1.1860	22-0064	1.0855	22-0123	1.0710
20-0002	1.0394	21-0005	1.1249	22-0003	1.0149	22-0065	1.0460	22-0126	1.0763
20-0003	1.0132	21-0006	1.0503	22-0004	1.0500	22-0066	1.0916	22-0128	1.0649
20-0005	.9714	21-0007	1.1316	22-0005	1.0124	22-0067	1.1152	22-0129	1.0683
20-0006	1.0168	21-0008	1.0889	22-0006	1.0948	22-0068	.9373	* 22-0130	.8748
20-0007	.9863	21-0009	1.1551	22-0008	1.1228	22-0069	1.0008	22-0131	.9983
20-0008	1.0973	21-0010	.9992	22-0009	.9923	22-0070	1.0336	* 22-0133	.9459
20-0009	1.2182	21-0011	1.0896	22-0010	1.0801	22-0071	1.3760	22-0135	1.0700
20-0012	1.0153	21-0012	1.0857	22-0011	1.1204	22-0072	.9717	* 22-0153	.8645
20-0013	1.0606	21-0013	1.0941	22-0012	1.1164	22-0073	1.0552	22-0154	.9329
20-0015	1.0176	21-0015	1.1154	* 22-0014	.9750	22-0074	1.0290	22-0156	1.0487
20-0016	.9980	21-0016	1.1283	22-0015	1.1118	22-0075	.6230	22-0162	.9720
20-0017	1.0576	21-0017	1.0638	22-0016	1.0657	22-0076	1.0961	22-0163	1.2228
20-0018	1.0278	21-0018	1.1381	22-0017	1.1005	22-0077	1.1132	22-0171	1.2348
20-0019	1.1084	21-0019	1.1574	22-0019	1.0433	22-0079	1.1111	23-0001	.9684
20-0020	1.0029	21-0021	.9903	22-0020	1.0950	22-0080	1.0542	23-0002	1.0687
20-0021	1.0446	21-0022	1.1216	22-0021	1.0692	* 22-0081	.8834	23-0003	1.0892
* 20-0023	.8911	21-0023	1.1240	22-0022	.9330	22-0082	1.0513	23-0004	1.0978
20-0024	1.0771	21-0024	1.1571	22-0023	1.0161	22-0083	1.0553	23-0005	.9592
20-0025	1.0167	21-0025	1.0231	22-0024	1.0928	22-0084	.9993	23-0006	.9310
20-0026	.9758	21-0026	1.1061	22-0025	1.0893	22-0086	1.2005	23-0007	.8410
20-0027	1.0305	21-0027	1.0826	22-0026	1.0469	22-0087	.8742	* 23-0008	.9513
20-0028	.8993	21-0028	.9538	22-0028	1.0623	22-0088	1.1413	23-0011	1.0340
* 20-0029	.8341	21-0029	1.1682	22-0029	1.0088	22-0089	1.0278	23-0012	.9573
20-0031	1.0622	21-0030	.9736	22-0030	.9845	22-0090	.9752	23-0013	1.1130
20-0032	1.2217	21-0031	1.3379	22-0031	1.1018	* 22-0091	1.1029	23-0014	.9290
20-0033	1.2252	21-0032	1.0141	22-0033	1.0340	22-0092	1.0759	23-0015	.9740
20-0034	1.0034	21-0033	1.0383	22-0034	.9989	22-0094	1.0097	23-0017	1.1286
20-0037	1.0063	21-0034	1.0842	22-0035	1.1012	22-0095	1.0326	23-0019	1.1608
20-0038	.9629	21-0035	1.0260	22-0036	1.1360	22-0097	.9499	23-0020	1.0908
20-0039	1.1013	21-0036	1.0354	22-0038	1.0724	22-0098	.9898	23-0021	1.0901

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23-0022	1.0352	23-0087	1.0522	23-0146	1.1130	23-0208	.9804	24-0011	.9650
23-0024	1.1680	23-0089	1.0754	23-0147	1.0221	23-0211	.9526	24-0013	1.0063
23-0027	.9279	23-0090	1.0731	23-0149	.9541	23-0212	1.0166	24-0014	.8950
23-0029	1.0605	23-0092	1.0385	23-0150	1.0510	23-0213	.9733	24-0016	1.1454
23-0030	1.1263	23-0093	.9824	23-0151	1.1209	23-0216	1.0185	24-0017	.9702
23-0031	1.0636	23-0095	1.0167	23-0152	1.0040	23-0217	.9583	24-0018	1.0439
23-0032	1.2695	23-0096	.9551	23-0153	1.0729	23-0219	.9277	24-0019	.8819
23-0034	1.0322	23-0097	1.1004	23-0154	.9359	23-0221	1.0057	24-0020	.9670
23-0035	.9756	23-0098	1.1159	23-0155	.9281	23-0222	1.0540	24-0021	.9412
23-0036	1.0768	23-0099	.9793	23-0156	1.2181	23-0223	1.0657	24-0022	1.0012
23-0037	1.0628	23-0100	.9677	23-0157	1.0853	23-0224	.9286	24-0023	.9747
23-0038	1.3303	23-0101	.9823	23-0158	.9418	23-0225	.9959	24-0024	.9931
23-0039	1.1440	23-0102	1.0724	23-0159	1.0099	23-0227	.9992	24-0025	.9953
23-0040	1.0684	23-0103	.9594	* 23-0161	.8507	23-0228	1.1018	24-0026	1.1332
23-0041	1.0495	23-0104	1.1643	* 23-0162	.9122	23-0230	1.1027	24-0027	.9556
23-0042	1.0437	23-0105	1.1648	23-0163	.8140	23-0231	.9444	24-0028	.9996
23-0043	.8528	23-0106	1.0109	23-0165	1.1788	* 23-0232	.9400	24-0029	1.0552
23-0046	1.1290	23-0107	.9550	23-0167	1.0682	23-0235	.9706	24-0030	.9814
23-0047	1.0119	23-0108	1.0005	23-0168	.9775	23-0236	1.0135	24-0031	.9032
23-0051	.9524	23-0110	1.0366	23-0169	1.0731	23-0237	1.0454	* 24-0033	.8338
23-0052	1.0233	23-0111	.9198	* 23-0170	1.0616	23-0238	.9359	24-0036	1.0376
23-0053	1.2677	23-0113	.8222	23-0171	.9091	23-0239	.9743	24-0037	.9374
23-0054	1.1038	23-0114	.7375	23-0172	1.0217	23-0241	.9633	24-0038	1.1108
23-0055	.9545	23-0115	.9726	23-0173	1.0398	23-0244	1.0353	24-0040	1.0081
23-0056	.9174	23-0116	.9404	23-0174	1.0264	23-0253	.9854	24-0041	1.0902
23-0057	.9261	23-0117	1.2480	23-0175	1.0687	23-0254	1.0412	24-0043	1.0826
23-0058	.9616	23-0118	.9968	23-0176	.9781	23-0255	.9263	24-0044	1.0217
23-0059	1.1477	23-0119	.9517	23-0177	.9469	23-0256	.9779	24-0045	1.0477
23-0061	.9874	23-0120	.9371	23-0178	.9548	23-0257	.8808	24-0046	1.1560
23-0062	.9766	23-0121	.9387	* 23-0179	.9752	* 23-0258	1.0079	24-0047	1.0904
23-0063	1.1055	23-0122	1.1144	23-0180	.9314	23-0259	.9562	24-0048	.8959
23-0065	1.0275	* 23-0123	.9917	23-0181	1.0110	23-0261	.9214	24-0049	1.2813
23-0066	1.0457	23-0124	.9620	23-0183	1.0031	23-0264	.8772	24-0050	1.0450
* 23-0067	1.0845	23-0125	1.1132	23-0184	.9285	23-0265	1.0251	24-0051	1.0010
23-0068	1.1545	23-0128	1.0558	23-0186	.9236	23-0266	1.0126	24-0052	1.0800
23-0069	1.0468	23-0129	1.2222	23-0188	.9488	23-0269	1.0547	24-0053	1.1423
23-0070	1.0550	23-0130	1.1437	23-0189	1.0176	23-0270	1.0600	24-0054	.9837
* 23-0071	.8333	23-0132	1.1141	* 23-0190	.8368	23-0271	.9425	24-0055	1.0975
23-0072	.9993	23-0133	1.0595	23-0191	.8730	* 23-0272	.9660	24-0056	1.0470
23-0075	1.0727	23-0134	1.0621	23-0193	1.0149	23-0273	1.1709	24-0057	1.1405
23-0076	1.0635	23-0135	1.0575	23-0194	1.0518	24-0001	1.1200	* 24-0058	.8842
23-0077	1.1086	23-0137	1.0053	23-0195	1.0813	24-0002	1.1281	24-0059	.9382
23-0078	.9278	* 23-0138	.8944	* 23-0196	.9290	24-0003	1.0405	24-0061	1.1568
23-0079	1.0153	23-0139	.9367	23-0197	1.0365	24-0004	1.2734	24-0062	1.0451
23-0080	.9590	23-0140	.9524	23-0199	.9684	* 24-0005	.9712	24-0063	1.0950
23-0081	1.0119	23-0141	1.1356	23-0201	.9362	24-0006	.9450	24-0064	.9896
23-0082	1.0066	23-0142	1.1282	* 23-0203	.8411	24-0007	.9134	24-0065	.9073
23-0084	.9423	23-0143	1.0450	23-0204	1.1133	24-0008	1.0126	24-0066	.9587
23-0085	.9174	23-0144	.9640	23-0205	1.0821	24-0009	.8950	24-0069	.9657
23-0086	.9450	23-0145	1.0005	23-0207	1.0026	24-0010	1.3895	24-0071	.9605

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 12

PROVIDER NUMBER	CASE MIX INDEX
24-0072	.8222
24-0073	.9130
24-0074	.8752
24-0075	.9339
24-0076	.9721
24-0077	.9534
24-0078	1.0248
24-0079	.9036
24-0080	1.1540
24-0081	1.1226
24-0082	1.1233
24-0083	1.0034
24-0084	1.0369
24-0085	.9380
24-0086	.9187
24-0087	1.0874
24-0088	1.0921
24-0089	.9716
24-0090	.9960
* 24-0091	.8966
24-0093	1.1343
24-0094	.9883
24-0096	.9614
24-0097	1.0680
24-0098	.8585
24-0099	.9422
24-0100	.9688
24-0101	1.0012
24-0102	.9193
24-0103	.9451
24-0104	.9808
24-0105	.8945
24-0106	1.1511
24-0107	.8999
24-0108	.9163
24-0109	.9367
24-0110	1.0056
24-0111	.8554
24-0112	.9230
24-0114	.9981
24-0115	1.1096
24-0116	.9385
24-0117	.9734
* 24-0118	.8565
* 24-0119	.9079
24-0120	1.0441
24-0121	.8929
24-0122	.9424
24-0123	1.0043
24-0124	.9603
* 24-0125	.9851
* 24-0127	.9177
24-0128	1.0353
24-0129	.9310
24-0130	.9318
24-0131	1.0914
24-0132	1.0222
24-0133	.9449
24-0134	.9991
* 24-0135	.7673
24-0136	.9484
24-0137	.9445
24-0138	.9277
24-0139	1.0546
* 24-0140	.9546
24-0141	.9094
24-0142	.9791
* 24-0143	.9427
24-0144	.9451
* 24-0145	.8650
24-0146	.8759
* 24-0148	.9009
24-0150	.8836
24-0152	.9588
24-0153	.9358
24-0154	.8975
24-0155	.9028
* 24-0156	.9408
24-0157	.9809
24-0158	.9804
24-0160	.9598
24-0161	.8726
24-0162	1.0457
* 24-0163	.8375
* 24-0165	.9575
24-0166	.9476
* 24-0167	.9711
24-0169	.9358
24-0170	.9890
24-0171	.8899
24-0172	1.0088
24-0173	.9526
24-0175	1.0362
* 24-0176	1.0251
* 24-0177	.9334
24-0179	.9393
24-0180	.9083
24-0183	.8928
* 24-0184	.9664
24-0187	.9601
* 24-0189	.8866
* 24-0192	.8474
* 24-0193	1.0278
* 24-0194	.8868
* 24-0195	1.0512
24-0196	1.0864
* 24-0200	1.0219
* 24-0201	.9029
* 24-0204	1.0355
25-0001	1.2191
25-0002	.8921
25-0003	.8625
25-0004	1.0664
25-0005	.8959
25-0006	.9593
25-0007	.9961
25-0008	.8665
25-0009	1.0087
25-0010	.8812
25-0012	.9510
25-0014	.8995
25-0015	.8968
25-0016	.8497
25-0017	.9303
25-0018	.9288
25-0019	1.0827
25-0020	.9160
25-0021	.9002
25-0023	.8388
25-0024	.9121
25-0025	.9465
25-0026	.8344
25-0027	.9356
25-0029	.9334
25-0030	.9132
25-0031	1.0279
25-0032	1.0534
25-0033	.8983
25-0034	.8715
25-0035	.9447
25-0036	.8618
25-0037	.9271
25-0038	.9142
25-0039	.8664
25-0040	1.0201
25-0041	.8957
25-0042	.9965
25-0043	.8357
25-0044	.8783
25-0045	.9749
25-0046	.9159
25-0047	.8940
25-0048	1.1494
25-0049	.9255
25-0050	.9851
25-0051	.9377
* 25-0054	.9136
25-0057	.9451
25-0058	.9919
25-0059	.8961
25-0060	.9139
25-0061	.9153
25-0062	.9288
25-0063	.8733
25-0065	.9245
25-0066	.8765
25-0067	.9375
25-0068	.8567
25-0069	1.0010
25-0071	.9685
25-0072	1.0273
25-0073	.9419
25-0075	.9071
25-0076	.8516
25-0077	.9046
25-0078	1.0535
* 25-0079	.9380
25-0080	.9363
25-0081	1.0674
25-0082	1.0475
25-0083	.9142
25-0084	.9577
25-0085	.8883
25-0086	.9019
* 25-0087	.9578
25-0088	.9532
25-0089	.9936
25-0091	.9802
25-0093	.9470
25-0094	1.0130
25-0095	.8524
25-0096	.9758
25-0097	.9781
25-0098	.8437
25-0099	.9716
25-0100	1.0533
* 25-0101	.8603
25-0102	1.0449
25-0103	.8964
25-0104	1.0482
25-0105	.8514
* 25-0106	.9617
25-0107	.8977
25-0109	.9361
25-0110	.9658
25-0111	.8626
25-0112	.8660
25-0113	.9875
* 25-0114	.9063
* 25-0116	.8799
25-0117	.9704
25-0118	1.1073
25-0119	.9110
25-0120	1.0279
* 25-0121	.8468
25-0122	.8881
25-0123	.9257
25-0124	.8461
25-0125	1.0594
25-0126	.9385
* 25-0127	1.0294
25-0128	.9731
25-0129	.9344
* 25-0130	.9012
* 25-0131	.8633
25-0132	.9443
* 25-0133	.8452
* 25-0134	.9787
26-0001	.9644
26-0002	.9760
26-0003	.8945
26-0004	.9927
26-0005	.9590
26-0006	.9707
26-0007	.8953
26-0008	1.0054
26-0009	.9322
26-0010	.9614
26-0011	.9505
26-0012	.8546
26-0013	.9324
26-0014	.9735
26-0015	.9031
26-0016	.9535
26-0017	.9627
26-0018	.9506
26-0019	.9283
26-0020	.9704
26-0021	.9500
26-0022	.9547

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 5a HOSPITAL CASE MIX INDEXES Page 13

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
26-0023	.9153	26-0082	.9438	* 26-0146	1.0181	* 27-0027	.9490	28-0014	.8279
26-0024	.9829	26-0083	.9712	26-0147	.9331	27-0028	.9417	28-0015	.8809
26-0025	.9210	26-0084	.9589	26-0148	.8746	27-0029	.9094	28-0017	.9270
* 26-0026	1.0170	26-0085	.9953	26-0150	1.0352	* 27-0030	.9040	28-0018	.8896
26-0027	1.0792	* 26-0086	1.1100	26-0158	.9628	* 27-0031	.8988	28-0020	1.1066
26-0029	.9282	26-0088	.8732	26-0159	.8431	27-0032	.9623	28-0021	.9512
26-0030	.9339	26-0089	.9329	26-0160	1.0073	* 27-0033	.8449	* 28-0022	1.0049
26-0031	.9682	26-0090	1.0125	26-0162	.9831	27-0035	.9876	28-0023	1.0940
26-0032	1.0257	26-0091	1.0110	26-0163	.8918	* 27-0036	1.0833	28-0024	.8972
26-0033	.9945	26-0092	.8941	* 26-0164	.8924	27-0039	.9156	28-0025	.8989
26-0034	.9170	* 26-0093	.9800	26-0165	.9064	27-0040	1.0056	* 28-0026	.8580
26-0035	.8850	26-0094	.9346	26-0166	.9959	27-0041	1.0437	28-0028	.9489
26-0036	.9142	26-0095	.9412	26-0172	.9036	* 27-0042	.8319	* 28-0029	.9457
26-0037	.9322	26-0096	1.0226	* 26-0173	.9660	27-0043	.8881	28-0030	1.1435
26-0039	.9779	26-0097	.9186	26-0175	.9815	27-0044	1.0093	28-0031	.9067
26-0040	1.0646	26-0100	.9276	26-0176	.9454	27-0046	.9132	28-0032	.9558
* 26-0041	.9710	* 26-0102	.9959	26-0177	1.0081	* 27-0047	1.0169	28-0033	.8678
26-0042	.7859	26-0103	.9968	26-0178	.9355	27-0048	.9130	28-0034	1.0480
26-0044	.9556	26-0104	1.0058	26-0179	.9867	27-0049	1.1399	28-0035	.9352
26-0045	.9641	26-0105	1.2045	26-0180	.9842	27-0050	.9492	28-0037	1.0073
26-0047	.9308	* 26-0106	.8694	* 26-0182	.9038	27-0051	.9831	28-0038	.9523
26-0048	1.0269	26-0107	.9496	26-0183	.9198	* 27-0052	.9202	28-0039	.8805
* 26-0049	.9620	26-0108	.9835	26-0186	.9706	* 27-0053	.9622	28-0040	1.1572
26-0050	.9045	* 26-0109	.9157	* 26-0187	1.0212	27-0054	1.0716	28-0041	.8828
26-0051	.9812	26-0110	.9594	26-0188	.9590	27-0057	1.0499	28-0042	.8660
26-0052	.9894	26-0111	.9231	* 26-0189	.9921	27-0058	1.0114	28-0043	.9727
26-0053	.9643	26-0112	.9957	26-0190	1.1026	* 27-0059	.8726	28-0045	.9956
26-0054	.9649	26-0113	.9468	26-0191	.9102	* 27-0060	.9411	28-0046	.9703
26-0055	.9035	26-0115	.9790	26-0192	.6325	* 27-0061	.9799	28-0047	1.0296
26-0056	.9158	26-0116	.9124	* 26-0193	.8196	* 27-0063	.9714	28-0048	.9766
26-0057	.9627	* 26-0117	.9501	* 27-0001	.9560	27-0065	1.0095	28-0049	.9450
26-0058	1.0491	26-0118	1.0480	27-0002	.9860	* 27-0067	.9620	* 28-0050	.8994
26-0059	.9515	26-0119	.9357	27-0003	1.0115	* 27-0068	.7694	28-0051	.9311
26-0061	.9217	26-0120	.9517	27-0004	1.3210	* 27-0070	.9134	28-0052	.9781
26-0062	.9694	26-0121	.9700	* 27-0006	.8997	* 27-0071	.8458	28-0054	1.0389
26-0063	1.0457	26-0122	.9597	27-0007	.9377	* 27-0072	.9772	28-0055	1.0058
26-0064	.9622	* 26-0123	1.0046	27-0008	.8427	* 27-0073	.8259	* 28-0056	.8730
26-0065	1.0444	26-0127	.9554	27-0009	.9368	* 27-0079	1.0242	28-0057	.9139
26-0066	.9198	26-0128	.9418	27-0011	.9962	27-0080	.9823	28-0058	1.0419
26-0067	.9021	26-0129	.8653	27-0012	1.0398	* 27-0081	.8917	28-0060	1.0656
26-0068	1.0179	26-0131	.9346	27-0013	1.0006	28-0001	.9406	28-0061	1.0217
26-0070	.9391	* 26-0133	.9302	27-0014	1.0960	28-0003	1.0863	28-0062	.9484
* 26-0072	.8490	26-0134	.9431	* 27-0016	.8855	28-0004	1.0572	* 28-0063	.7933
26-0073	.8225	26-0136	.9398	27-0017	1.0804	28-0005	1.1059	28-0064	.9530
26-0074	.9675	26-0137	.9291	27-0018	.9102	28-0006	1.0326	28-0065	.9742
26-0077	.9567	26-0138	1.1557	* 27-0019	.8785	28-0009	1.0231	28-0066	.9890
26-0078	.9558	* 26-0140	1.2003	27-0021	.9631	28-0010	1.0548	28-0068	.9595
26-0079	.9272	26-0141	1.0604	27-0023	1.1087	28-0011	.9380	* 28-0070	.8623
* 26-0080	1.0343	26-0142	.9863	27-0024	1.0212	28-0012	.9814	* 28-0071	.9270
26-0081	.9821	* 26-0143	.9603	* 27-0026	.9051	28-0013	1.1002	28-0073	.8898

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 14

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
28-0074	1.0289	* 29-0013	.6597	31-0015	1.0960	31-0070	1.0536	32-0018	1.0059
28-0075	.9726	* 29-0014	1.0151	31-0016	1.1085	31-0071	1.0804	32-0019	1.0040
28-0076	.9315	* 29-0015	.9930	31-0017	1.1523	31-0072	1.0768	32-0021	1.1639
28-0077	.9993	* 29-0016	1.0624	31-0018	.9787	31-0073	1.0272	32-0022	1.0315
* 28-0078	.8858	* 29-0018	.6031	31-0019	1.0951	31-0074	1.0366	32-0023	.8735
28-0079	.9294	29-0019	1.0605	31-0020	1.0467	31-0075	1.1427	32-0027	.9523
28-0080	.8883	* 29-0020	.5352	31-0021	1.0751	31-0076	1.1005	32-0030	.9663
28-0081	1.0496	29-0021	1.0904	31-0022	1.0882	31-0077	1.1304	* 32-0031	.9315
28-0082	.9424	29-0022	1.1776	31-0024	1.1180	31-0078	1.1169	32-0032	.9578
28-0083	.9457	29-0024	.8157	31-0025	1.0936	31-0081	1.1154	32-0033	1.0266
28-0084	.9439	* 29-0027	.9567	31-0026	1.1187	31-0083	1.0242	32-0035	.9305
28-0085	1.0672	30-0001	1.0626	31-0027	1.0293	31-0084	1.0749	32-0036	1.1487
28-0087	1.0595	30-0002	.9741	31-0028	1.0569	31-0085	1.0174	32-0037	.9401
28-0088	1.0779	30-0003	1.1819	31-0029	1.2483	31-0086	1.0579	32-0038	.9487
28-0089	.9877	30-0005	.9971	31-0031	1.3207	31-0087	1.0287	32-0046	1.0988
28-0090	.9650	30-0006	.9597	31-0032	.9895	31-0088	1.0745	32-0048	1.0943
28-0091	1.0010	30-0007	.9384	31-0033	1.0555	31-0090	1.0206	32-0049	.9361
28-0092	.9385	30-0008	1.0189	31-0034	1.0798	31-0091	1.0166	* 32-0051	.9649
28-0093	.8676	30-0009	.8804	31-0036	1.0578	31-0092	1.0290	32-0053	.8844
28-0094	.9857	30-0010	.9994	31-0037	1.0913	31-0093	.9869	* 32-0058	.9535
28-0097	.8671	30-0011	.9992	31-0038	1.0798	31-0094	.9889	32-0063	1.0416
* 28-0098	.9802	30-0012	1.0274	31-0039	1.0524	31-0096	1.2247	32-0065	1.0216
* 28-0100	.8165	30-0013	1.0017	31-0040	1.0365	31-0104	.9909	* 32-0066	.9907
* 28-0101	.9180	30-0014	1.0027	31-0041	1.0710	31-0105	1.0052	* 32-0067	.8004
* 28-0102	1.0040	30-0015	.9829	31-0042	1.0500	31-0106	1.2050	* 32-0068	.8874
28-0103	.9752	30-0016	1.0131	31-0043	.9773	31-0108	1.0989	* 32-0069	.8979
28-0104	.9310	30-0017	.9052	31-0044	1.0680	31-0110	1.0527	* 32-0070	.9775
28-0105	1.1237	30-0018	.9756	31-0045	1.0901	31-0111	1.1177	* 32-0071	.8792
28-0106	.8789	30-0019	1.0318	31-0046	1.0617	31-0112	1.0997	33-0001	1.0707
28-0107	.8592	30-0020	.9870	31-0047	1.1547	31-0113	1.0318	33-0002	1.0852
28-0108	.9354	30-0021	.9215	31-0048	1.1085	31-0115	1.0557	33-0003	1.0985
28-0109	.9743	30-0022	.9373	31-0049	1.0498	31-0116	1.1307	33-0004	1.0721
28-0110	.9892	30-0023	1.0989	31-0050	1.0937	31-0117	1.1102	33-0005	1.1711
28-0111	.9747	30-0024	.9893	31-0051	1.1191	31-0118	1.0360	33-0006	1.0927
* 28-0114	.9218	30-0028	.9610	31-0052	1.0896	31-0119	1.0545	33-0007	1.0835
28-0115	.9347	30-0029	.9965	31-0053	1.0204	31-0120	.9947	33-0008	1.0168
* 28-0116	.9174	30-0033	1.0008	31-0054	1.1130	32-0001	1.1152	33-0009	.9728
28-0117	.9483	30-0034	1.0394	31-0056	1.0607	32-0002	1.0754	33-0010	1.0223
28-0118	.9424	31-0001	1.1071	31-0057	1.1844	32-0003	.9701	33-0011	1.0800
29-0001	1.1310	31-0002	1.2552	31-0058	1.0344	32-0004	.8990	33-0012	1.1143
* 29-0002	.9180	31-0003	1.0655	31-0059	1.0421	32-0005	1.0387	33-0013	1.1827
29-0003	1.0872	31-0005	1.0424	31-0060	1.0512	32-0006	.9850	33-0014	1.1195
29-0004	.9375	31-0006	1.0930	31-0061	1.0492	32-0009	1.0646	33-0015	1.0311
29-0006	.9524	31-0008	1.0950	31-0062	.9188	32-0010	1.0269	33-0016	.9488
29-0007	1.1624	31-0009	.9945	31-0063	1.1017	32-0011	1.0163	33-0019	1.0086
29-0008	.9312	31-0010	1.1064	31-0064	1.0868	32-0012	.9105	33-0020	.9321
29-0009	1.0545	31-0011	1.0063	31-0065	1.0511	32-0013	.9888	33-0022	1.0063
29-0010	.9113	31-0012	1.1359	31-0067	1.0537	32-0014	.8386	33-0023	1.0816
* 29-0011	.8946	31-0013	1.0653	31-0068	1.0371	32-0016	1.0045	33-0024	1.2231
29-0012	1.1681	31-0014	1.1715	31-0069	1.0405	32-0017	1.0669	33-0025	.9994

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3 A HOSPITAL CASE MIX INDEXES Page 15

PROVIDER NUMBER	CASE MIX INDEX
33-0027	1.1568
33-0028	1.1000
33-0029	1.0881
33-0030	.9901
33-0032	1.0244
33-0033	1.0796
33-0034	1.0166
33-0036	.9811
33-0037	1.0347
33-0038	.9770
33-0039	1.0497
33-0041	1.0334
33-0042	1.0369
33-0044	1.1218
33-0045	1.1361
33-0046	1.1211
33-0047	1.0517
33-0048	1.0661
33-0049	1.0643
33-0050	.9954
33-0052	.9577
33-0053	.9650
33-0055	1.1121
33-0056	1.0973
33-0057	1.1700
33-0058	1.0612
33-0059	1.1475
33-0061	1.1003
33-0062	.9374
33-0063	1.0309
33-0064	1.1060
33-0065	1.0396
33-0066	1.0373
33-0067	1.0176
33-0069	1.1045
33-0072	1.1107
33-0073	1.0287
33-0074	1.0515
33-0075	.9582
33-0076	1.0459
33-0077	.9745
33-0078	1.1013
33-0079	1.0304
33-0080	1.0165
33-0082	1.0240
33-0084	1.0201
33-0085	1.1516
33-0086	1.0412
33-0087	1.0157
33-0088	1.0735
33-0090	1.2251
33-0091	1.1041
33-0092	1.0457
33-0094	1.0626
33-0095	1.0544
33-0096	.9804
33-0097	.9803
33-0098	1.0529
33-0100	.6004
33-0101	1.2181
33-0102	1.0728
33-0103	1.1154
33-0104	1.1164
33-0106	1.1934
33-0107	.9918
33-0108	1.0468
33-0109	.9744
33-0110	.8375
33-0111	1.0875
33-0114	.9619
33-0115	1.0590
33-0116	.9167
33-0117	1.0633
33-0118	1.1670
33-0119	1.0664
33-0120	1.2460
33-0121	.9859
33-0122	1.0275
33-0124	1.0004
33-0125	1.2926
33-0126	1.0589
33-0127	1.0748
33-0128	1.1179
33-0132	1.0034
33-0133	1.0475
33-0134	1.0091
33-0135	1.0392
33-0136	1.1556
33-0139	1.0244
33-0140	1.1922
33-0141	1.0800
33-0142	1.0605
33-0143	1.0425
33-0144	1.0347
33-0146	.9432
33-0148	.9610
33-0150	.8648
33-0151	1.0140
33-0152	1.0912
33-0153	1.0988
33-0154	1.2640
33-0155	1.0282
33-0157	1.0659
33-0158	1.0628
33-0159	1.1886
33-0160	1.0955
33-0161	.9691
33-0162	1.1546
33-0163	.9961
33-0164	1.2089
33-0165	.9417
33-0166	1.0457
33-0167	1.1779
33-0168	1.0165
33-0169	1.0373
33-0171	1.1459
33-0172	.9834
33-0174	.9227
33-0175	1.0321
33-0176	.9614
33-0177	.8571
33-0179	.8857
33-0180	1.0152
33-0181	1.1301
33-0182	1.4320
33-0183	1.1687
33-0184	1.1186
33-0185	1.1468
33-0186	1.0037
33-0188	1.0661
33-0189	.7159
33-0191	1.1037
33-0193	1.1702
33-0194	1.1064
33-0195	1.2097
33-0196	1.1279
33-0197	.9373
33-0198	1.0912
33-0199	1.0833
33-0201	1.0811
33-0202	1.0452
33-0203	1.1069
33-0204	1.0981
33-0205	1.0164
33-0208	1.0613
33-0209	1.0500
33-0210	.9254
33-0211	1.0233
33-0212	.9992
33-0213	.9730
33-0214	1.2031
33-0215	.9964
33-0217	1.0142
33-0218	.9970
33-0219	1.1063
33-0221	1.0512
33-0222	1.0143
33-0223	.9113
33-0224	1.0632
33-0225	1.0908
33-0226	1.0164
33-0229	1.0657
33-0230	1.0298
33-0231	1.0120
33-0232	1.0488
33-0233	1.0865
33-0234	1.1982
33-0235	1.0735
33-0236	1.1379
33-0238	1.0087
33-0239	1.0850
33-0240	1.0837
33-0241	1.2926
33-0242	1.1195
33-0244	1.0890
33-0245	1.0816
33-0246	1.0420
33-0247	.6252
33-0249	1.0115
33-0250	1.0200
33-0252	.8745
33-0254	1.0387
33-0256	.9811
33-0257	1.0552
33-0258	1.0920
33-0259	1.0583
33-0260	1.0813
33-0261	1.1243
33-0263	1.0096
33-0264	1.0187
33-0265	1.0718
33-0266	.8913
33-0267	1.0505
33-0268	1.0409
33-0270	1.5653
33-0272	1.0135
33-0273	1.0301
33-0275	1.1081
33-0276	.9637
33-0277	.9725
33-0279	1.0998
33-0281	.9534
33-0283	.9941
33-0285	1.2526
33-0286	1.1182
33-0288	1.1165
33-0290	1.2041
33-0291	.9870
33-0293	1.0680
33-0297	1.0436
33-0298	.9786
33-0299	1.0555
33-0300	.8906
33-0304	1.1065
33-0305	1.0328
33-0306	1.1225
33-0307	.9876
33-0308	1.1567
33-0309	1.0575
33-0314	1.0316
33-0315	1.1244
33-0316	1.0730
33-0318	1.0805
33-0320	1.0562
33-0323	.9037
33-0324	1.0485
33-0327	.9465
33-0331	1.0617
33-0332	.9698
33-0333	.8983
33-0335	1.0876
33-0336	1.0547
33-0338	1.0322
33-0339	.9743
33-0340	.9705
33-0342	1.0631
33-0345	.7929
33-0350	1.3625
33-0351	.9095
33-0353	1.0596
33-0354	1.0517
33-0355	.9424
33-0357	1.0703
33-0359	1.0117
33-0372	1.0078
33-0377	.8905
33-0382	1.0292
33-0383	1.0506
33-0385	1.0565
33-0386	1.0233

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 16

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
* 33-0387	.9398	* 34-0048	.8616	34-0109	1.0377	35-0011	1.2418	36-0011	1.0796
33-0389	1.2152	34-0045	.8589	34-0111	1.0052	35-0012	.9328	36-0012	1.4608
33-0390	.9752	34-0050	1.0301	34-0112	.9553	35-0013	1.0078	36-0013	1.0238
33-0391	1.2093	34-0051	1.0809	34-0113	1.2067	35-0014	.8766	36-0014	.9537
* 33-0392	.6925	34-0052	.8838	34-0114	1.0484	35-0015	1.1057	36-0015	1.1237
33-0393	1.1718	34-0053	1.0003	34-0115	1.0584	35-0016	1.0155	36-0016	1.1150
33-0394	1.0248	34-0054	.9077	34-0116	1.0335	35-0017	1.0131	36-0017	.9883
34-0001	.9741	34-0055	.9726	34-0117	.9773	35-0018	.9567	36-0018	1.0505
34-0002	1.1400	* 34-0056	.9608	34-0119	1.0044	35-0019	1.0875	36-0019	1.0409
34-0003	1.0405	* 34-0057	1.0531	34-0120	.9806	35-0020	1.0380	36-0020	1.1056
34-0004	1.0236	* 34-0058	1.0752	34-0121	.9397	* 35-0021	.9119	36-0021	.9931
34-0005	.9905	34-0060	.9955	* 34-0122	.5160	35-0023	1.0153	36-0022	1.0285
34-0006	.5681	34-0061	1.1783	34-0123	1.0102	35-0024	.9512	36-0023	1.0295
34-0007	1.0058	34-0063	1.0023	34-0124	.9331	* 35-0025	.8645	36-0024	1.0183
34-0008	.9985	34-0064	1.0206	34-0125	1.0693	* 35-0027	.8704	36-0025	.9981
34-0009	.5144	34-0065	1.0398	34-0126	1.0907	35-0029	.8971	36-0026	1.0028
34-0010	.9796	34-0067	.9137	34-0127	1.0247	35-0030	.9782	36-0027	1.1155
34-0011	.9845	34-0068	.9898	34-0128	.9549	* 35-0031	.9170	36-0028	.9949
34-0012	.9789	34-0069	1.1732	34-0129	.9703	35-0032	.9798	36-0029	1.0437
34-0013	1.0099	34-0070	1.0106	34-0130	1.0217	35-0033	.9452	36-0030	1.0109
34-0014	1.1303	34-0071	.9409	34-0131	1.0431	35-0034	1.0534	36-0031	1.0144
34-0015	.9909	34-0072	.9590	34-0132	1.0114	* 35-0035	.9173	36-0032	1.0423
34-0016	.5427	34-0073	.9790	34-0133	1.0075	* 35-0036	1.2218	36-0033	.9773
34-0017	1.0251	34-0075	.9454	34-0141	1.0749	* 35-0037	.9749	36-0034	.9620
34-0018	1.0222	34-0076	.9780	34-0142	1.0741	35-0038	.9155	36-0035	1.1233
34-0015	.9777	* 34-0077	.9453	34-0143	.9256	35-0039	.9529	36-0036	.9439
34-0020	1.0158	* 34-0078	.9382	34-0144	.9936	35-0041	.9835	36-0037	1.1652
34-0021	1.0000	* 34-0079	.5001	34-0145	.5350	* 35-0042	.9055	36-0038	.9396
34-0022	.9519	34-0080	.9130	* 34-0146	.5714	35-0043	1.0368	36-0039	.9894
34-0023	.9727	34-0084	1.0024	34-0147	1.0595	35-0044	.9927	36-0040	1.0036
34-0024	1.0054	34-0085	1.0074	34-0148	.5563	* 35-0045	.8731	36-0041	1.1285
34-0025	.5611	34-0086	.8971	* 34-0150	1.0683	35-0047	.9444	36-0042	.9897
34-0026	.9728	34-0087	.9174	34-0151	.9405	* 35-0048	.8176	36-0044	.9619
34-0027	.9826	34-0088	.9856	34-0153	1.4737	* 35-0049	1.1046	36-0045	1.0771
34-0028	1.0533	34-0089	.9673	34-0155	1.1230	35-0050	.9277	36-0046	.9283
34-0030	1.1685	34-0090	1.0533	34-0157	.7927	35-0051	.9237	36-0047	.9730
34-0031	.9671	34-0091	1.1142	34-0158	.9663	* 35-0053	.9083	36-0048	1.2269
34-0032	1.0805	34-0092	.9497	34-0159	1.1848	* 35-0055	.8444	36-0049	1.0857
34-0034	1.0289	34-0093	1.0536	34-0160	.9757	35-0056	1.0108	36-0050	.9790
34-0035	.8948	34-0094	.9662	34-0162	.8613	* 35-0058	.9643	36-0051	1.1254
34-0036	.9876	34-0096	.9677	35-0001	.9186	* 35-0060	.9139	36-0052	1.1578
34-0037	.9526	34-0097	1.0448	35-0002	1.0391	35-0061	.9721	36-0053	1.0776
34-0038	.9646	34-0098	1.0293	35-0003	1.0331	36-0001	1.0895	36-0054	1.1116
34-0039	.9841	34-0099	.9603	35-0004	1.1571	36-0002	.9625	36-0055	1.0974
34-0040	1.1093	34-0100	1.0567	* 35-0005	1.1135	36-0003	1.0940	36-0056	1.0224
34-0041	1.0171	34-0101	.9882	35-0006	1.0913	36-0006	1.1718	36-0057	1.0020
34-0042	1.0318	34-0104	.9199	35-0007	.9269	36-0007	.9259	36-0058	.9586
34-0044	.9854	34-0105	1.1105	35-0008	.9307	36-0008	.9790	36-0059	1.1235
34-0045	.9658	* 34-0106	.8760	35-0009	.9720	36-0009	1.0952	36-0060	.9223
34-0047	1.2335	34-0107	.9824	35-0010	.9393	36-0010	1.0342	* 36-0061	.9028

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 17

PROVIDER NUMBER	CASE MIX INDEX
36-0062	1.1544
36-0063	.8658
36-0064	1.1829
36-0065	1.1058
36-0066	1.0667
36-0067	1.0041
36-0068	1.1507
36-0069	.9993
36-0070	1.0933
36-0071	.9924
36-0072	1.0804
36-0074	1.0359
36-0075	1.1012
36-0076	.9501
36-0077	1.0830
36-0078	.9825
36-0079	1.2200
36-0080	.9633
36-0081	1.0383
36-0082	1.1571
36-0083	1.0172
36-0084	1.0879
36-0085	1.1935
36-0086	1.0338
36-0087	1.1116
36-0088	.9955
36-0089	1.0159
36-0090	1.0401
36-0091	1.0473
36-0092	.9971
36-0093	.9100
36-0094	1.0636
36-0095	1.0227
36-0096	.9950
36-0097	1.0243
36-0098	1.1312
36-0099	.9826
36-0100	1.0466
36-0101	1.1817
36-0102	1.1652
36-0103	1.0859
36-0104	1.0052
36-0106	1.0791
36-0107	.9999
36-0108	1.0231
36-0109	1.0235
* 36-0110	.8935
36-0112	1.1642
36-0113	1.1358
36-0114	.9545

PROVIDER NUMBER	CASE MIX INDEX
36-0115	1.0000
36-0116	.9414
36-0118	1.1334
36-0119	.9808
36-0120	.9272
36-0121	1.1484
36-0122	1.0133
36-0123	1.0655
36-0124	1.0460
36-0125	1.0383
36-0126	1.0077
36-0127	.9767
36-0128	.9670
36-0129	.9113
36-0130	.9889
36-0131	1.0519
36-0132	1.0124
36-0133	1.0582
36-0134	1.1740
36-0135	.9492
36-0136	.9489
36-0137	1.2097
36-0139	.9762
36-0140	.8724
36-0141	1.1088
36-0142	.9103
36-0143	1.0616
36-0144	1.0320
36-0145	1.1032
36-0147	.9634
36-0148	1.0261
36-0149	.9417
36-0150	1.0525
36-0151	1.0654
36-0152	1.0898
36-0153	1.0404
36-0154	1.0588
36-0155	1.0752
36-0156	.9481
36-0159	1.0809
36-0161	.9793
36-0162	1.0396
36-0163	1.1769
36-0164	.9659
36-0165	1.0014
36-0166	.9560
36-0167	.9606
36-0168	.9213
36-0169	.9278
36-0170	1.0265

PROVIDER NUMBER	CASE MIX INDEX
36-0171	1.0938
36-0172	1.0445
36-0174	.5680
36-0175	.5584
36-0176	1.0147
36-0177	1.0918
36-0178	.9198
36-0179	1.0498
36-0180	1.2534
36-0184	.9930
36-0185	1.0499
36-0186	.9275
36-0187	1.0512
36-0188	.9658
36-0189	.9954
36-0190	1.0679
36-0192	1.0675
36-0193	1.0552
36-0194	.9926
36-0195	1.0265
36-0197	.9712
36-0200	.9887
36-0203	.9831
36-0204	1.0782
36-0210	.9511
36-0211	.9764
36-0212	1.1325
36-0213	.9947
36-0218	1.0783
36-0220	1.1072
36-0231	.9767
36-0232	1.0383
36-0234	1.0488
36-0236	1.1009
* 36-0237	.7847
* 36-0238	.9432
36-0239	1.0575
36-0345	.9899
37-0001	1.1255
37-0002	.9834
* 37-0003	.8822
37-0004	.9952
37-0005	.9382
37-0006	1.0279
37-0007	1.0877
37-0008	1.0420
37-0011	.9587
37-0012	.9018
37-0013	1.0845
37-0014	.9531

PROVIDER NUMBER	CASE MIX INDEX
37-0015	.9608
37-0016	.9962
37-0017	.9076
37-0018	1.0054
37-0019	.8402
37-0020	.9963
37-0021	.9500
37-0022	1.0255
37-0023	1.0188
37-0025	1.0122
37-0026	1.0173
37-0028	1.2163
37-0029	.9646
37-0030	1.0015
37-0032	.9443
37-0033	.9760
37-0034	.9932
37-0035	1.2044
37-0036	.8567
37-0037	1.1276
37-0038	.8961
37-0039	.9826
37-0040	.9518
37-0041	.9457
37-0042	.8995
37-0043	.8652
37-0045	.9202
37-0046	.9134
37-0047	.9496
37-0048	.8820
37-0049	1.0442
37-0050	.8428
37-0051	.9990
37-0054	1.0056
37-0056	1.0518
37-0057	1.0434
37-0059	.9242
37-0060	.9893
37-0061	.9341
37-0063	.9210
37-0064	.9293
37-0065	.9527
37-0069	.9568
37-0071	.8754
37-0072	.8873
37-0076	1.0016
37-0077	.9764
37-0078	1.0240
37-0079	.9619
37-0080	.9963

PROVIDER NUMBER	CASE MIX INDEX
37-0082	.9106
37-0083	.8954
37-0084	.8921
37-0085	.9673
37-0086	1.0435
37-0089	.9394
37-0090	.9999
37-0091	1.1486
37-0092	.9452
37-0093	1.0779
37-0094	1.0269
37-0095	.8612
* 37-0096	.8888
37-0097	.9353
37-0098	.8436
37-0099	.8841
37-0100	.8725
37-0103	.8297
37-0105	1.4783
37-0106	.9301
37-0107	.9141
37-0108	.9427
* 37-0109	.9113
37-0110	.9251
37-0112	.9040
37-0113	.9019
37-0114	1.1370
37-0116	.8567
37-0117	.9884
37-0121	1.0397
37-0122	.9038
37-0123	.9674
37-0125	.8649
37-0126	1.0155
37-0130	.9780
* 37-0131	.8865
37-0133	.9134
37-0136	.9288
37-0138	.8483
37-0139	.9997
37-0140	.8988
37-0141	1.0358
37-0144	1.0192
* 37-0146	.8437
37-0148	1.0321
37-0149	1.0381
37-0153	.9367
37-0154	.9479
37-0156	.9291
37-0157	.9119

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 18

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
37-0158	.9127	38-0039	1.0715	39-0006	1.1436	39-0058	1.0721	39-0112	1.0510
37-0159	1.0243	38-0040	.9400	39-0007	1.0298	39-0059	1.1402	39-0113	1.0157
37-0161	1.0204	38-0041	.8696	39-0008	1.0156	39-0060	1.0690	39-0114	1.0837
37-0162	.8728	38-0042	.9850	39-0009	1.1233	39-0061	1.0849	39-0115	1.1414
37-0165	.8425	38-0043	.9894	39-0010	1.0774	39-0062	.9557	39-0116	.9872
37-0166	.8721	* 38-0044	.8237	39-0011	1.1019	39-0063	1.1498	39-0117	1.0054
* 37-0168	.9874	38-0045	1.0737	39-0012	1.0437	39-0064	1.1415	39-0118	.9534
37-0169	.9466	38-0047	1.1668	39-0013	.9767	39-0065	1.0619	39-0119	1.0595
37-0176	.9470	38-0048	.9716	39-0014	.9684	39-0066	1.0203	39-0120	1.0328
* 37-0177	1.0181	38-0050	1.1133	39-0015	1.0674	39-0067	1.1552	39-0121	1.0640
37-0178	.9450	38-0051	1.1105	39-0016	1.0367	39-0068	1.0696	39-0122	.9651
* 37-0179	.8989	38-0052	1.0269	39-0017	1.0228	39-0069	1.0162	39-0123	1.0854
* 37-0180	1.0253	* 38-0054	.8491	39-0018	1.0770	39-0070	1.0286	39-0125	1.0178
* 37-0181	.8430	38-0055	1.1223	39-0019	1.0016	39-0071	1.0387	39-0126	1.1532
* 37-0182	.8461	38-0056	1.0097	39-0020	1.0052	39-0072	.9451	39-0127	1.0920
37-0183	.9819	* 38-0059	.9955	39-0021	1.1208	39-0073	1.0897	39-0128	1.0515
* 37-0184	.8629	38-0060	1.1123	39-0022	1.1046	39-0074	1.1130	39-0130	.9994
38-0001	1.0744	38-0061	1.1552	39-0023	1.0745	39-0075	1.0788	39-0131	1.0946
38-0002	1.0186	* 38-0062	.9218	39-0024	.8069	39-0076	1.0302	39-0132	.9771
38-0003	1.1055	38-0063	1.0768	* 39-0025	.9388	39-0077	1.1055	39-0133	1.1867
38-0004	1.2504	38-0064	1.0051	39-0026	1.1525	39-0078	.9577	39-0135	1.1171
38-0005	.9453	38-0065	.8970	39-0027	1.1783	39-0079	1.2673	39-0136	1.0486
38-0006	.9698	38-0066	1.0498	39-0028	1.2008	39-0080	1.1272	39-0137	1.0927
38-0007	1.1346	* 38-0067	.8543	39-0029	1.1751	39-0081	1.0898	39-0138	1.0961
38-0008	1.0419	38-0068	1.0221	39-0030	1.0073	39-0082	.9883	39-0139	1.1548
38-0009	1.1940	38-0069	.8637	39-0031	1.0187	39-0083	1.1348	39-0142	1.1643
38-0010	1.1183	38-0070	1.0181	39-0032	1.0900	39-0084	.9850	39-0143	.7425
38-0011	1.0279	38-0071	1.0905	39-0034	1.0420	39-0086	1.0332	39-0145	1.0743
38-0013	.9988	38-0072	.9935	39-0035	1.1584	39-0087	.9579	39-0146	.9705
38-0014	1.0885	38-0074	.9591	39-0036	1.0277	39-0088	1.0060	39-0147	1.0260
* 38-0016	.8116	38-0075	1.0598	39-0037	1.0681	39-0090	1.1688	39-0148	1.0638
38-0017	1.1698	38-0077	.9402	39-0038	1.0694	39-0091	1.0183	39-0149	1.0167
38-0018	1.1393	38-0078	1.0513	39-0039	1.0191	39-0092	1.0336	39-0150	1.0053
38-0019	1.1874	38-0079	1.1512	39-0040	.9606	39-0093	1.0495	39-0151	1.0847
38-0020	1.0357	38-0081	.9335	39-0041	1.0789	39-0095	.9274	39-0152	.9963
38-0021	1.0401	38-0082	1.0666	39-0042	1.0320	39-0096	1.1145	39-0153	1.0971
38-0022	1.1219	38-0083	1.0300	39-0043	1.0302	39-0097	1.1207	39-0154	1.0410
38-0023	.9264	38-0084	1.0011	39-0044	1.1304	39-0098	1.1712	39-0155	1.0401
38-0024	1.0594	38-0087	.9149	39-0045	1.1232	39-0099	.9809	39-0156	1.0997
38-0025	1.0199	38-0088	.8695	39-0046	1.1702	39-0100	1.1075	39-0157	1.0135
38-0026	1.0577	38-0089	1.0801	39-0047	1.1586	39-0101	1.0554	39-0158	1.0732
38-0027	1.0579	38-0090	1.1300	39-0048	1.0956	39-0102	1.1027	39-0159	1.0777
38-0029	.9990	38-0091	1.0424	39-0049	1.1245	39-0103	.9400	39-0160	1.0009
38-0030	.8691	* 38-0093	.8194	39-0050	1.2457	39-0104	.9452	39-0161	.9495
38-0031	.9401	* 38-0094	.8473	39-0051	1.2259	39-0106	.9886	39-0162	1.0707
38-0033	1.1882	39-0001	1.1594	39-0052	1.0127	39-0107	1.0792	39-0163	1.1397
38-0035	1.0398	39-0002	1.0724	39-0054	1.0564	39-0108	1.0969	39-0164	1.2645
38-0036	1.0213	39-0003	1.0407	39-0055	1.2206	39-0109	.9741	39-0165	.9831
38-0037	1.0622	39-0004	1.0333	39-0056	1.0502	39-0110	1.0483	39-0166	1.0449
38-0038	1.1055	39-0005	.9678	39-0057	1.1322	39-0111	1.3768	39-0167	1.0790

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
39-0168	1.0296
39-0169	1.0846
39-0170	1.3111
39-0171	1.0564
39-0172	1.1009
39-0173	1.0125
39-0174	1.3002
39-0176	1.0156
39-0177	.9120
39-0178	1.1707
39-0179	1.0880
39-0180	1.0695
39-0181	.9947
39-0183	.9169
39-0184	.9331
39-0185	1.0842
39-0186	1.0343
39-0187	1.0254
39-0188	1.0219
39-0189	1.0100
39-0190	.9659
39-0191	.9519
39-0192	.9161
39-0193	1.0347
39-0194	.9857
39-0195	1.2539
39-0196	1.2122
39-0197	1.0204
39-0198	1.0026
39-0199	1.0026
39-0200	1.0758
39-0201	1.0867
39-0202	1.0921
39-0204	1.1139
39-0205	1.0547
39-0206	1.1282
39-0209	1.0082
39-0211	.9874
39-0213	.8861
39-0215	1.0197
39-0217	1.0402
39-0219	1.0379
39-0220	1.0677
39-0222	1.0329
39-0223	1.1655
39-0224	.9623
39-0225	1.0557
39-0226	1.2274
39-0228	1.1033
39-0229	1.1642
39-0231	1.1058
39-0232	1.0140
39-0233	1.1090
39-0234	1.0842
39-0235	1.1258
39-0236	1.0019
39-0237	1.0924
* 39-0238	.8421
39-0240	.9750
39-0242	1.0722
39-0244	.8741
39-0245	1.0583
39-0246	.9446
39-0247	1.0126
* 39-0248	1.3254
39-0249	.9531
* 39-0252	.8421
39-0256	1.2816
39-0258	1.1590
39-0260	1.1116
39-0261	1.4337
39-0262	.9566
39-0263	1.1069
39-0265	1.0866
39-0266	1.0072
39-0267	1.1041
39-0268	1.0543
39-0269	1.0581
39-0270	1.0079
41-0001	1.1671
41-0002	1.1419
41-0004	1.1600
41-0005	1.1154
41-0006	1.0272
41-0007	1.2133
41-0008	.9721
41-0009	1.1547
* 41-0010	.9250
41-0011	1.0369
41-0012	1.1392
41-0013	1.0159
41-0014	1.0062
41-0016	.8815
42-0002	.9587
42-0003	.9693
42-0004	.9422
42-0005	.9254
42-0006	.9979
42-0007	1.0074
42-0009	.9277
42-0010	.9179
42-0011	.8723
42-0014	.8506
42-0015	.9568
42-0016	.9478
42-0017	.8453
42-0018	1.0100
42-0019	.9654
42-0020	.9616
42-0022	.9688
42-0023	.9465
* 42-0024	.8990
42-0026	.9142
42-0027	.9578
42-0028	.9035
42-0029	1.0440
42-0030	.9026
42-0031	.9165
42-0032	1.0077
42-0033	.9922
42-0036	1.0166
42-0037	1.0705
42-0038	.9249
42-0039	.9353
42-0040	.9547
42-0042	.8870
42-0043	.9269
42-0044	.9234
42-0048	.9042
42-0049	.9206
42-0050	.9789
42-0051	.9752
42-0053	.9432
42-0054	1.0222
42-0055	.9029
42-0056	.9294
42-0057	.9190
42-0059	.9513
42-0061	.9388
42-0062	.9278
42-0064	.9128
42-0065	.9679
42-0066	.9034
42-0067	.9398
42-0068	.9629
42-0069	.9156
42-0070	.9763
42-0071	.9797
42-0072	.9237
42-0073	.9680
42-0074	.8984
42-0075	.8916
42-0076	.8662
* 42-0077	.8790
42-0078	.9164
42-0079	1.1670
42-0080	.9757
* 42-0081	.9106
42-0082	.9570
42-0083	.9175
* 42-0084	.7081
42-0085	.9578
42-0086	1.0027
42-0087	1.0379
* 42-0088	.8182
43-0001	1.0078
43-0004	.9762
43-0005	.9782
43-0007	.9632
43-0008	.9092
43-0009	1.0603
43-0010	.9381
43-0011	1.0255
43-0012	1.0129
43-0013	.9245
43-0014	1.0866
43-0015	.9406
43-0016	1.0928
43-0017	.8968
43-0018	.8715
43-0020	1.0227
43-0022	.9047
43-0023	.9364
43-0024	.9729
* 43-0025	.8603
* 43-0026	.9256
43-0027	1.1824
43-0028	.9313
43-0029	.8949
* 43-0030	.9588
43-0031	.8533
43-0033	.9459
43-0034	.8856
43-0036	1.0099
43-0037	.8821
43-0038	.9551
* 43-0039	.9286
43-0040	.9506
* 43-0041	.9002
43-0042	.9088
43-0043	.9891
43-0044	.9706
43-0047	.8958
43-0048	.9184
* 43-0049	.9482
* 43-0051	.8875
43-0054	.9157
* 43-0056	.8944
43-0057	.8753
* 43-0060	.8120
43-0062	.7729
43-0064	.8416
* 43-0065	.9263
43-0066	.8469
43-0072	.9549
43-0073	.9603
43-0076	.9809
43-0077	1.0850
* 43-0079	.9269
* 43-0080	.8998
43-0087	.8439
44-0001	.9338
44-0002	1.0785
44-0003	.9778
44-0005	.9321
44-0006	1.0028
44-0007	.9111
44-0008	.8963
44-0009	.9006
44-0010	.9068
44-0011	1.0544
44-0012	1.0241
44-0014	.9124
44-0015	1.0940
44-0016	.9447
44-0017	1.0036
44-0018	.9984
44-0019	1.0185
44-0020	.9153
44-0022	.9264
44-0023	.8699
44-0024	.9589
44-0025	.9489
44-0026	1.0677
* 44-0028	.9120
44-0029	.9276
44-0030	.9898
44-0031	.9189
44-0032	.8641
44-0033	.9484

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 20

PROVIDER NUMBER	CASE MIX INDEX
44-0034	1.0083
44-0035	1.0420
44-0036	.9381
44-0039	1.2889
44-0040	.9168
44-0041	.8904
* 44-0044	.7143
44-0046	.9524
44-0047	.9129
44-0048	1.1881
44-0049	1.1111
44-0050	.9869
44-0051	.9302
44-0052	.9224
44-0053	.9336
44-0054	.9400
* 44-0055	.8293
44-0056	.8747
44-0057	.9158
44-0058	.9166
44-0059	.9098
44-0060	.9034
44-0061	.9790
44-0063	1.0710
44-0064	.8574
44-0065	.9039
44-0067	.9196
44-0068	.9508
44-0069	.9624
44-0070	.9291
44-0071	1.0051
44-0072	1.0049
44-0073	1.0112
44-0074	.8190
44-0078	.9555
44-0079	.9063
44-0081	1.0117
44-0082	1.2130
44-0083	.8667
44-0084	.9443
* 44-0086	.9272
44-0087	.8825
* 44-0090	.8440
44-0091	1.0386
44-0095	.8652
44-0100	.8912
* 44-0101	.9051
44-0102	.9471
44-0103	.9369
44-0104	1.0256

PROVIDER NUMBER	CASE MIX INDEX
44-0105	.5525
44-0109	.9419
44-0110	.9136
44-0111	1.1246
44-0113	.8869
44-0114	.9130
44-0115	.9444
44-0117	.8080
44-0120	1.0542
44-0121	.9318
44-0123	.9541
44-0125	1.0525
44-0130	1.0013
44-0131	.9542
44-0132	.8581
44-0133	1.1839
44-0134	.9001
44-0135	.9437
44-0136	.9505
44-0137	.8763
44-0141	.9453
44-0142	.7948
44-0143	.9371
44-0144	.9113
44-0145	.9121
* 44-0146	.9710
* 44-0147	.6601
44-0148	.9199
44-0149	.8956
44-0150	1.0217
44-0151	.9021
44-0152	1.0729
44-0153	.8931
44-0156	1.0108
44-0157	.8904
44-0159	1.0280
44-0160	.9229
44-0161	1.0599
44-0162	.8901
44-0166	1.1648
44-0167	1.0541
44-0168	1.1194
44-0169	.6271
44-0170	.6472
44-0171	.9201
44-0173	.9747
44-0174	.9008
44-0175	.9236
44-0176	1.0016
44-0177	.9015

PROVIDER NUMBER	CASE MIX INDEX
44-0178	.9014
44-0180	.9308
44-0181	.8956
44-0182	.8691
44-0183	1.1206
44-0184	1.0724
44-0185	1.0134
44-0186	.9228
44-0187	.8603
44-0189	.9844
44-0191	.9104
44-0192	.9981
44-0193	.9846
44-0194	1.0105
44-0196	.8673
44-0197	1.1010
44-0200	.8473
45-0001	.9886
45-0002	.9836
45-0004	.9023
45-0005	.9433
45-0007	.9322
45-0008	.9350
45-0010	.9784
45-0011	.9348
45-0013	.9910
45-0014	.8851
45-0015	1.0901
45-0016	.9933
45-0018	1.0552
45-0019	.9892
45-0020	.9025
45-0021	1.0548
45-0022	.9225
45-0023	1.0007
45-0024	.9746
45-0025	1.0152
45-0027	.8588
45-0028	1.0261
45-0029	.9684
45-0031	.9588
45-0032	.9204
45-0033	.9946
45-0034	1.0143
45-0035	.9587
45-0037	.9882
45-0039	1.1286
45-0040	.9487
45-0041	.9283
45-0042	1.0002

PROVIDER NUMBER	CASE MIX INDEX
45-0043	.9430
45-0044	1.0250
* 45-0045	1.0360
45-0046	.9588
45-0047	.9667
45-0048	.9189
45-0050	.9893
45-0051	1.0168
45-0052	.9533
45-0053	1.0153
45-0054	1.0182
45-0055	.9084
45-0056	.9819
45-0057	.9374
45-0058	.9922
45-0059	.9682
45-0060	.9781
* 45-0063	.8766
45-0064	.9571
45-0065	.9168
45-0066	.9124
45-0068	.9903
* 45-0069	.9632
45-0070	.8780
45-0072	.8999
45-0073	.9112
45-0074	.9282
45-0076	1.0584
45-0077	.9001
45-0078	.8339
45-0079	.9547
45-0080	.9660
45-0081	.9490
45-0082	.8706
45-0083	.9567
45-0084	.9044
45-0085	.9289
* 45-0086	.5919
45-0087	.9468
45-0090	.8948
45-0092	.8929
* 45-0093	.9869
45-0094	.9329
45-0095	.8701
45-0096	.9579
45-0097	.9980
45-0098	.9517
45-0099	.9400
45-0101	.9269
45-0102	.8449

PROVIDER NUMBER	CASE MIX INDEX
45-0104	.9724
45-0107	1.0183
* 45-0108	1.0055
45-0109	.9143
45-0110	1.0171
45-0111	.9374
45-0112	.9262
45-0113	.9069
45-0115	.9277
45-0116	1.0063
45-0118	1.0444
45-0119	.9336
45-0121	.9568
* 45-0122	.7965
45-0123	.9580
45-0124	1.0599
45-0126	.9094
45-0127	.9597
45-0128	.8748
* 45-0129	.8428
45-0130	.9315
45-0131	.8831
45-0132	.9218
45-0133	1.0165
45-0134	.9608
45-0135	1.0444
* 45-0136	1.0614
45-0137	.9482
* 45-0140	.8575
45-0141	.8468
45-0142	.9215
* 45-0143	1.0436
45-0144	1.0023
* 45-0145	.8649
* 45-0146	.8732
45-0147	.9646
45-0148	.9449
45-0149	.9490
45-0150	.9456
45-0151	.9488
45-0152	1.0192
45-0153	.9831
45-0154	.8997
45-0155	.9335
45-0157	.9330
* 45-0160	.9190
45-0162	1.0377
45-0163	.9036
45-0164	.8554
45-0165	.8910

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
* 45-0166	.8610
45-0169	.9488
* 45-0170	.9027
45-0173	.8625
45-0174	.9591
45-0175	.9767
45-0176	.9595
45-0177	.8860
* 45-0178	.9079
45-0179	.9444
* 45-0181	.8546
45-0182	.8747
45-0183	.9428
45-0184	.9622
45-0185	.8596
* 45-0186	.9867
45-0187	.9757
45-0188	.9266
45-0190	.9882
45-0191	.9552
45-0192	.9244
45-0193	1.1852
45-0194	.9710
45-0195	.9426
45-0196	.9176
45-0197	.9133
45-0198	.8855
45-0200	.9546
45-0201	.8532
45-0203	.9050
45-0206	.9111
45-0207	.8655
45-0208	.9176
45-0209	1.0026
45-0210	.9050
45-0211	.9881
45-0213	1.0813
45-0214	.8559
* 45-0215	.7973
45-0216	.9911
45-0217	.9118
45-0218	.9174
45-0219	.9110
45-0221	.8664
45-0222	.9822
45-0224	.9957
45-0225	.9066
* 45-0230	.8956
45-0231	1.0165
45-0233	.8697
45-0234	.8626
45-0235	.9954
45-0236	.8780
45-0237	1.0121
45-0239	.9862
45-0241	.8569
* 45-0242	.8844
* 45-0243	.9124
45-0244	.9044
45-0246	.8544
45-0247	.9096
45-0248	.8918
45-0249	.9036
45-0250	.8302
45-0253	.9670
45-0256	.9010
45-0258	.8754
45-0259	1.0154
* 45-0260	.8722
45-0261	.9219
* 45-0263	.9431
* 45-0264	.8843
* 45-0265	.8376
* 45-0267	.9090
45-0268	.9341
* 45-0269	.9033
45-0270	.9423
45-0271	.9603
45-0272	.9284
* 45-0274	.8225
45-0275	.9235
45-0276	.9339
45-0278	.8801
45-0280	.9815
45-0281	.9256
45-0282	.9064
45-0283	.9005
45-0284	.8616
45-0286	.9715
45-0288	.9322
45-0289	.9654
45-0292	.9963
45-0293	.8672
45-0296	.8752
45-0297	.8745
45-0299	.9002
45-0300	.9416
45-0303	.9279
45-0304	.8813
* 45-0305	.9573
45-0306	.8623
* 45-0307	.7899
45-0309	.9592
45-0311	.8742
45-0312	.9273
45-0315	.9242
45-0317	.8655
45-0319	.9196
45-0320	1.0014
45-0321	.9260
* 45-0322	.8024
45-0324	.9870
45-0325	.9443
45-0327	.7962
45-0328	.8566
45-0330	.9534
45-0331	.8782
45-0332	.8772
45-0333	.9810
45-0334	.9561
* 45-0335	.8913
45-0337	.9765
* 45-0338	1.0130
45-0340	.8826
45-0341	.8951
* 45-0342	.9252
45-0343	.8803
45-0346	.9468
45-0347	.8934
45-0348	.8931
45-0349	.9303
45-0351	.9326
45-0352	.9789
45-0353	.9506
* 45-0355	.9424
45-0357	.9648
45-0358	1.0750
* 45-0359	1.0499
45-0362	.9072
45-0365	.9365
45-0366	.9657
45-0369	.9061
45-0370	.7397
45-0371	.9058
45-0372	1.0286
45-0373	.9349
* 45-0374	.8965
45-0376	.9339
45-0378	1.0025
45-0379	1.0080
45-0381	.9547
45-0382	.8449
45-0388	.9795
45-0389	.9687
45-0391	.9760
45-0393	.9125
45-0394	.9271
45-0395	.8604
45-0398	.8822
45-0399	.9591
45-0400	.8527
45-0402	.9508
45-0403	.9080
* 45-0405	1.1684
45-0410	.8714
45-0411	.8850
45-0415	.9568
45-0416	.9814
45-0417	.8972
45-0418	.9708
45-0419	.8904
* 45-0421	.9775
45-0422	.5411
45-0423	.7937
45-0424	.9350
45-0425	.8940
45-0429	.9147
45-0431	.9141
45-0438	.9207
* 45-0440	.8591
* 45-0446	.9539
45-0447	1.0694
45-0450	.8269
* 45-0451	.7982
45-0454	.9156
45-0455	.8796
45-0457	1.0650
* 45-0458	.8336
45-0459	.8454
45-0460	.8679
45-0462	1.0075
45-0464	.8847
45-0465	.8954
45-0467	.9180
45-0469	.9377
45-0472	.9677
45-0473	.9114
45-0475	.9199
45-0476	.8953
45-0481	.8954
* 45-0482	.9105
45-0484	.9409
45-0486	.9008
45-0488	.9183
45-0489	.8876
* 45-0490	.9014
45-0492	.8934
45-0493	.8719
45-0497	.9414
45-0498	.9162
45-0508	1.0109
45-0513	.8632
45-0514	.9877
45-0517	.8323
45-0518	1.0252
45-0523	1.0247
45-0527	.8860
45-0530	.9441
45-0534	.8623
45-0535	.9344
45-0537	.9718
45-0538	.9328
45-0539	.9256
45-0544	.9362
45-0545	.8856
45-0546	.9374
45-0547	.8818
45-0550	1.0186
45-0551	.9159
45-0552	.9082
* 45-0557	.9265
45-0558	.9385
* 45-0559	.8889
45-0561	.8983
45-0563	.8778
45-0565	.9651
45-0568	1.0093
45-0569	.9974
45-0570	.8961
45-0571	.9884
45-0573	.8736
45-0574	.9195
45-0575	1.0019
45-0577	.8737
* 45-0578	.9076
* 45-0579	.8813
45-0580	.9763
45-0581	.9319
* 45-0582	.8724
* 45-0583	.8221

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 22

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
45-0584	.8535	45-0651	1.0862	* 45-0706	.9857	47-0016	.9271	49-0048	1.0334
45-0586	.9287	45-0652	.8562	46-0001	1.0254	47-0018	.9547	49-0050	1.0803
45-0587	.9282	45-0653	.9701	46-0003	1.0681	* 47-0020	.9265	* 49-0051	1.0335
45-0588	.9664	45-0654	.9205	46-0004	1.0855	47-0023	.9435	49-0052	1.0734
45-0590	.9341	* 45-0655	.9524	46-0005	.9546	47-0024	.9576	49-0053	1.0719
45-0591	.8962	45-0656	.9345	46-0006	1.0434	48-0001	.9970	49-0054	.9467
45-0592	.9975	* 45-0657	.8949	46-0007	1.0015	48-0002	.9477	49-0055	.9010
45-0595	.9453	45-0658	.8899	46-0008	1.0302	49-0001	.9536	49-0056	.8233
45-0596	.9723	45-0659	1.0655	46-0009	1.1584	49-0002	.8822	49-0057	1.0614
45-0597	.8769	45-0660	1.0184	46-0010	1.1425	49-0003	.5799	49-0059	1.1129
45-0600	.9658	* 45-0661	.9153	46-0011	1.0131	49-0004	1.0534	49-0060	.9194
* 45-0601	.8602	45-0662	1.0413	46-0012	1.1321	49-0005	1.0918	49-0063	1.1684
* 45-0603	.8630	45-0665	.8625	46-0013	.9540	49-0006	.9935	49-0066	1.0461
45-0604	.9410	45-0666	.9563	* 46-0014	1.0508	49-0007	1.1950	49-0067	1.0266
45-0605	.9330	45-0667	.8950	46-0015	.9932	49-0008	.9928	49-0069	1.0772
* 45-0607	.8471	45-0668	.9495	46-0016	.9402	49-0009	1.2700	49-0071	1.0622
45-0609	.8612	45-0669	1.0072	46-0017	1.0854	49-0010	.9715	49-0073	.9937
45-0610	.9511	45-0670	.9424	* 46-0018	.9740	49-0011	1.1117	49-0074	.9731
45-0611	.9192	45-0671	.9491	* 46-0019	.8904	49-0012	.9269	49-0075	1.0398
45-0613	.9247	45-0672	.9867	* 46-0020	.9694	49-0013	1.0269	49-0077	1.0363
45-0614	.8830	* 45-0673	.9642	46-0021	1.0212	49-0014	1.0581	49-0078	.8829
45-0615	.8837	* 45-0674	.8254	* 46-0022	.9723	49-0015	1.0896	49-0079	1.0296
* 45-0616	.9179	45-0675	1.0250	46-0023	.9891	49-0017	1.0981	49-0083	.9535
45-0617	1.0593	* 45-0676	.8609	* 46-0024	.8690	49-0018	1.0109	49-0084	.9272
* 45-0618	.8862	45-0677	.9829	* 46-0025	.8435	49-0019	1.0046	49-0085	.8819
45-0620	.8918	45-0678	.9230	46-0026	.8752	49-0020	.9501	49-0088	.9534
45-0621	.9177	45-0679	.9369	* 46-0027	.8264	49-0021	1.0299	49-0089	.9320
45-0623	.9335	45-0681	.9545	* 46-0029	.8898	49-0022	.9719	49-0090	1.0218
45-0624	.9016	45-0682	.9028	46-0030	1.0205	49-0023	1.0727	49-0091	1.1151
45-0626	.8826	45-0683	.9402	* 46-0032	.9128	49-0024	1.1107	49-0092	.9970
45-0627	.8646	45-0684	1.0288	* 46-0033	.9657	49-0027	1.0082	49-0093	1.0323
45-0628	.8864	45-0685	.8987	* 46-0035	.9272	49-0028	1.0557	49-0094	1.0094
45-0629	.9216	45-0686	1.0537	* 46-0036	.8464	49-0029	.9999	49-0095	1.0228
45-0630	1.1784	45-0687	.9722	46-0037	.9908	49-0030	.9494	49-0097	1.0161
45-0631	1.1791	45-0688	1.0055	* 46-0038	1.0251	49-0031	1.0272	49-0098	1.0205
45-0632	.8935	45-0690	1.0460	* 46-0039	.9337	49-0032	1.3347	49-0099	.9566
45-0633	.9823	* 45-0691	.9974	* 46-0040	.8194	49-0033	1.0259	49-0100	1.0523
45-0634	1.0538	* 45-0693	.8490	46-0041	1.0147	49-0034	.8661	49-0101	1.0457
45-0635	1.1044	45-0694	.5890	46-0042	1.0947	49-0035	.9023	* 49-0104	1.0536
45-0637	.9485	45-0695	.8154	47-0001	1.0074	49-0037	.9962	49-0107	.9579
45-0638	.9566	45-0696	.8508	47-0003	1.1952	49-0038	1.0013	49-0110	.9437
45-0639	.9549	45-0697	1.0079	47-0004	1.0491	* 49-0039	.8315	49-0111	.9582
45-0641	.9071	45-0698	.8650	47-0005	1.0046	49-0040	1.0954	49-0112	1.1454
45-0642	.9150	45-0699	.9352	47-0006	.8514	49-0041	.9070	49-0113	1.0125
45-0644	1.0156	45-0700	.8766	47-0008	.9455	49-0042	.9930	49-0114	.9866
45-0645	1.0152	* 45-0701	.8792	47-0010	1.0212	49-0043	.9952	49-0115	.9709
45-0647	1.1791	45-0702	.9384	47-0011	.9357	49-0044	.9964	49-0116	.9767
45-0648	.9447	45-0703	.9303	47-0012	1.0441	49-0045	1.1164	49-0117	.9781
45-0649	.9208	45-0704	.8647	47-0013	1.0117	49-0046	1.0549	49-0118	1.0856
* 45-0650	.8206	* 45-0705	.7538	47-0015	1.0710	49-0047	1.0935	49-0119	1.0813

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERIA FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

PROVIDER NUMBER	CASE MIX INDEX
49-0120	1.1419
49-0122	1.1050
49-0123	1.1050
49-0124	1.0271
* 49-0125	.7661
49-0126	.9935
49-0127	.9642
50-0001	1.1115
50-0002	1.0546
50-0003	1.0520
50-0005	1.2008
50-0006	1.0971
50-0007	1.1018
50-0008	1.3425
50-0009	1.0167
50-0010	1.1090
50-0011	1.0376
50-0012	1.1831
50-0014	1.1016
50-0015	1.1142
50-0016	1.1583
50-0017	1.1128
50-0019	1.0327
50-0020	1.0858
50-0021	1.1576
50-0022	.9862
50-0024	1.1953
50-0025	1.4125
50-0026	1.0829
50-0027	1.1987
50-0028	.9625
50-0029	.8550
50-0030	1.1864
50-0031	1.0363
50-0032	.9881
50-0034	.9713
50-0035	1.0452
50-0036	1.0438
50-0037	1.0253
50-0038	1.1232
50-0040	.9227
50-0041	1.1154
50-0042	.9347
* 50-0043	.5182
50-0044	1.2015
50-0045	1.0452
50-0046	1.1289
50-0048	1.0151
50-0049	1.1098
50-0050	.9555
50-0051	1.1453
50-0052	.9577
50-0053	1.0902
50-0054	1.1854
50-0055	1.0015
50-0057	1.0206
50-0058	1.0740
50-0059	.9561
50-0060	.9915
50-0061	.9833
* 50-0062	1.0287
50-0064	1.1139
50-0065	1.0221
* 50-0066	.7883
50-0068	.9228
50-0069	.9256
50-0070	.9969
50-0071	1.0021
50-0072	1.0612
* 50-0073	.9906
50-0074	.8896
50-0075	1.0264
50-0076	.9518
50-0077	1.0854
50-0078	1.0603
50-0079	1.0671
* 50-0080	.7897
50-0081	.5735
50-0084	1.0786
50-0085	.8664
50-0086	.9865
50-0087	1.0951
50-0088	1.0554
50-0089	1.0643
* 50-0090	.7980
* 50-0092	.9846
50-0093	1.0425
50-0094	.8150
50-0096	.9863
50-0097	1.0252
* 50-0098	.8788
* 50-0100	.9668
50-0101	.9279
* 50-0102	.5032
50-0104	1.0521
* 50-0106	.8332
50-0107	.5928
50-0108	1.2193
50-0109	.9536
50-0110	1.0895
50-0111	1.1112
50-0118	1.0620
50-0119	1.0226
* 50-0121	.5237
50-0122	1.1391
* 50-0123	1.0264
50-0124	1.1361
* 50-0125	1.0155
* 50-0127	.8194
50-0129	1.1829
50-0130	.8120
* 50-0132	.5323
51-0001	1.1357
51-0002	1.0171
51-0003	1.0150
* 51-0004	.9083
51-0005	.9445
51-0006	1.0332
51-0007	1.0738
51-0008	1.0243
51-0009	.9795
* 51-0011	1.0343
51-0012	.9319
51-0013	.9730
51-0014	.9672
51-0015	.9693
51-0016	.9304
51-0018	1.0011
* 51-0019	.5526
51-0020	1.0253
51-0022	1.1713
51-0023	1.0197
51-0024	1.0476
51-0025	.9083
51-0026	.9258
51-0027	.9713
51-0028	.9186
51-0029	1.0160
51-0030	.9575
51-0031	.9533
51-0033	1.1249
51-0035	.9665
51-0036	.8573
51-0038	.9658
51-0039	1.0826
* 51-0040	.8995
* 51-0041	.8643
* 51-0043	.5502
51-0045	.9049
51-0046	1.0098
51-0047	1.0409
51-0048	.9360
51-0050	.9995
51-0052	.9733
51-0053	.9819
51-0054	.8739
51-0055	1.0007
51-0058	1.1020
51-0059	.6972
51-0060	.9343
51-0061	1.0094
51-0062	.9854
51-0063	.9118
51-0064	.9435
51-0065	.8868
51-0066	1.0072
51-0067	.7935
51-0068	.9455
51-0070	1.0025
51-0071	.9983
51-0072	.9415
51-0074	.9200
* 51-0076	.8332
51-0077	.9993
51-0080	.9391
51-0081	.9190
51-0082	.9558
* 51-0083	1.0264
51-0084	.9114
52-0001	1.0504
52-0002	1.0937
52-0003	.9690
52-0004	.9844
52-0006	1.0247
52-0007	.9630
52-0008	.9837
52-0009	1.0875
52-0010	1.0290
52-0011	.9900
52-0012	.9688
52-0013	1.0001
52-0014	1.0323
52-0015	1.1151
52-0016	.9945
52-0017	1.0065
52-0018	.9419
52-0019	1.0788
52-0020	1.0474
52-0021	1.0104
52-0022	.9474
52-0024	.8822
52-0025	.9436
52-0026	1.0809
52-0027	.9274
52-0028	1.0831
52-0029	.9215
52-0030	1.0835
52-0031	1.0037
52-0032	1.0706
52-0033	1.0264
52-0034	.9994
52-0035	1.0455
52-0037	1.2080
52-0038	1.0239
52-0039	.9805
52-0040	1.0656
52-0041	.9240
52-0042	.9689
52-0043	1.1278
52-0044	1.0060
52-0045	1.1357
52-0047	.9357
52-0048	1.0390
52-0049	1.2907
52-0051	1.1577
52-0053	.9608
52-0054	.9893
52-0056	1.0067
52-0057	.8910
52-0058	.9612
52-0059	.9832
52-0060	.9931
52-0062	1.0305
52-0063	1.0530
52-0064	1.1446
52-0066	1.0332
52-0067	1.1307
52-0068	.9087
52-0069	.9828
52-0070	1.0799
52-0071	1.0065
52-0074	.9549
52-0075	1.0264
52-0076	.9799
52-0077	.8965
52-0078	1.1014
52-0081	1.1486
52-0082	.9717
52-0083	1.1348
52-0084	.9425

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

TABLE NO. 3a HOSPITAL CASE MIX INDEXES Page 24

PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX	PROVIDER NUMBER	CASE MIX INDEX
52-0087	1.1425	52-0112	.9396	52-0135	1.0400	52-0161	.9014	53-0008	.9574
52-0088	1.0933	52-0113	.9780	52-0136	1.0884	* 52-0164	.8194	53-0009	.9445
52-0089	1.0739	52-0114	.9198	52-0138	1.2047	* 52-0165	.8757	53-0010	1.0170
52-0090	.9255	52-0115	1.0573	52-0139	1.0442	52-0167	.9620	53-0011	1.0919
52-0091	1.0339	52-0116	1.0002	52-0140	1.0873	52-0170	1.0195	53-0012	1.0588
52-0092	.9520	52-0117	.9757	52-0141	1.0612	52-0171	.8855	53-0015	.9940
52-0094	1.0451	52-0118	.9264	* 52-0142	.9243	52-0173	.9723	53-0016	.9997
52-0095	.9578	52-0119	.9428	* 52-0143	.9135	52-0174	1.1057	* 53-0017	.9316
52-0096	1.1377	* 52-0120	1.1297	52-0144	1.0248	* 52-0175	.8194	53-0018	.8243
52-0097	1.0299	52-0121	1.1022	52-0145	.9961	* 52-0176	.7895	53-0019	.8440
52-0098	1.2397	52-0122	.9882	52-0146	.9278	52-0177	1.1405	* 53-0021	.9321
52-0100	1.0606	52-0123	1.0863	52-0148	.9311	52-0178	.9735	53-0022	.9425
52-0101	.9410	52-0124	.9328	52-0149	.9637	* 52-0179	.8194	* 53-0023	.7906
52-0102	1.0271	52-0125	.8269	52-0151	.9411	* 52-0180	.8194	* 53-0024	.9282
52-0103	1.1217	52-0126	.9649	52-0152	.9841	53-0001	1.0338	53-0025	.9396
52-0104	.9020	52-0127	.9720	52-0153	1.0404	53-0002	1.0746	53-0026	.8943
* 52-0105	.9169	* 52-0129	.8519	52-0154	.9765	* 53-0003	.9331	* 53-0027	.9491
52-0107	.9893	52-0130	.9099	52-0156	.9639	53-0004	1.0450	* 53-0029	.9590
52-0109	.9444	52-0131	.9638	52-0157	.9830	* 53-0005	1.0770	* 53-0031	.8191
52-0110	.9190	52-0132	.9973	52-0159	.9524	53-0006	.9996		
52-0111	1.0312	52-0134	.9678	52-0160	1.1446	53-0007	.9001		

INDEXES DERIVED FROM FEWER THAN 50 DISCHARGES DO NOT MEET THE SELECTED STATISTICAL PRECISION CRITERION FOR RELIABILITY. THESE CASE MIX INDEXES ARE ASTERISKED.

BILLING CODE 4120-03-C

TABLE 3b.—AVERAGE CASE-MIX INDEXES BY HOSPITAL CLASSIFICATION GROUP

Bed size	Mean case-mix index
Urban Hospitals:	
Less than 100	0.9692
100 to 404	1.0485
405 to 684	1.1077
685 and above	1.1408
Rural Hospitals:	
Less than 100	.9449
100 to 169	.9881
170 and above	1.0262

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

MSA area	Wage index
Abilene, TX	.9414
Taylor, TX	
Akron, OH	1.0734
Portage, OH	
Summit, OH	
Albany, GA	[1].8907
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.8925
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schnectady, NY	
Albuquerque, NM	1.0579
Bernalillo, NM	
Alexandria, LA	.9735
Rapides, LA	
Allentown-Bethlehem, PA-NJ	1.0518
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Alton-Granite City, IL	.9587
Jersey, IL	
Madison, IL	
Altoona, PA	1.0249
Blair, PA	
Amarillo, TX	.9696
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2445
Orange, CA	
Anchorage, AK	1.4657
Anchorage, AK	
Anderson, IN	.9690
Madison, IN	
Anderson, SC	.8748
Anderson, SC	
Ann Arbor, MI	1.2090
Washtenaw, MI	
Anniston, AL	.8625
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	.9704
Calument, WI	
Outagamie, WI	
Winnebago, WI	
Asheville, NC	.9508
Buncombe, NC	
Athens, GA	.8817
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	.9417
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	1.0649
Atlantic, NJ	
Cape May, NJ	
Augusta, GA-SC	.9514
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	.9958
Kane, IL	
Kendall, IL	
Austin, TX	1.0590
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.2271
Kern, CA	
Baltimore, MD	1.0960
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	.9271
Penobscot, ME	
Baton Rouge, LA	1.0174
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	1.0600
Calhoun, MI	
Beaumont-Port Arthur, TX	.9874
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0663
Beaver, PA	
Bellingham, WA	[1] 1.0544
Whatcom, WA	
Benton Harbor, MI	.8734
Berrien, MI	
Bergen-Passaic, NJ	1.0290
Bergen, NJ	
Passaic, NJ	
Billings, MT	[1].9648
Yellowstone, MT	
Biloxi-Gulfport, MS	.8710
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9528
Broome, NY	
Tioga, NY	
Birmingham, AL	1.0047
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	1.0100
Burleigh, ND	
Morton, ND	
Bloomington, IN	[1].9143
Monroe, IN	
Bloomington-Normal, IL	[1] 1.0139
McLean, IL	
Boise City, ID	1.0755
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0949
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	.9982
Boulder, CO	
Bradenton, FL	[1].9199
Manatee, FL	
Brazoria, TX	.8409
Brazoria, TX	
Bremerton, WA	[1].8989
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1572
Fairfield, CT	
Brownsville-Harlingen, TX	.9217
Cameron,TX	
Bryan-College Station, TX	.9077
Brazos, TX	
Buffalo, NY	.9787
Erie, NY	
Burlington, NC	.8480
Alamance, NC	
Burlington, VT	[1].9654
Chittenden, VT	
Grand Isle, VT	
Canton, OH	.9797
Carroll, OH	
Stark, OH	
Casper, WY	1.0255
Natrona, WY	
Cedar Rapids, IA	.9379
Linn, IA	
Champaign-Urbana-Rantoul, IL	1.0245
Champaign, IL	
Charleston, SC	1.0262
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	1.1033
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	.9776
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	1.2925
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	.9671
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Chicago, IL	1.2196
Cook, IL	
DuPage, IL	
McHenry,IL	
Chico, CA	1.0558
Butte, CA	
Cincinnati, OH-KY-IN	1.0558
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	.8342
Christian, KY	
Montgomery,TN	
Cleveland, OH	1.2026
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.1069
El Paso, CO	
Columbia, MO	1.1357
Boone, MO	
Columbia, SC	.9803

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Lexington, SC	
Richland, SC	
Columbus, GA-AL	.9199
Russell, AL	
Chattahoochee, GA	
Muscogee, GA	
Columbus, OH	1.0423
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.9648
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.9460
Allegany, MD	
Mineral, WV	
Dallas, TX	1.0774
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	[1].8701
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-ILL	.9621
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.1117
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	.9693
Volusia, FL	
Decatur, IL	[1].9831
Macon, IL	
Denver, CO	1.2141
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	1.0709
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.1992
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.8846
Dale, AL	
Houston, AL	
Dubuque, IA	1.0281
Dubuque, IA	
Duluth, MN-WI	.9154
St. Louis, MN	
Douglas, WI	
East St Louis-Belleville, IL	.9717
Clinton, IL	
St. Clair, IL	
Eau Claire, WI	.9703
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.8991
El Paso, TX	
Elkhart-Goshen, IN	[1].8907
Elkhart, IN	
Elmira, NY	1.0257
Chemung, NY	
Enid, OK	.9018
Garfield, OK	
Erie, PA	.9927
Erie, PA	
Eugene-Springfield, OR	.9862
Lane, OR	
Evansville, IN-KY	1.0093
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0051
Clay, MN	
Cass, ND	
Fayetteville, NC	[1].9325
Cumberland, NC	
Fayetteville-Springdale, AR	.8307
Washington, AR	
Flint, MI	1.1523
Genesee, MI	
Florence, AL	.8088
Colbert, AL	
Lauderdale, AL	
Florence, SC	.8072
Florence, SC	
Fort Collins-Loveland, CO	.9278
Larimer, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.1105
Broward, FL	
Fort Myers, FL	.9242
Lee, FL	
Fort Pierce, FL	.9843
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	.9705
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	[1].7673
Okaloosa, FL	
Fort Wayne, IN	.9446
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	.9261
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.1951
Fresno, CA	
Gadsden, AL	.9234
Etowah, AL	
Gainesville, FL	.9709
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.1822
Galveston, TX	
Gary-Hammond, IN	1.1222
Lake, IN	
Porter, IN	
Glens Falls, NY	.8813
Warren, NY	
Washington, NY	
Grand Forks, ND	[1].9762
Grand Forks, ND	
Grand Rapids, MI	.9998
Kent, MI	
Ottawa, MI	
Great Falls, MT	[1] 1.0307
Cascade, MT	
Greeley, CO	[1] 1.0629
Weld, CO	
Green Bay, WI	.9974
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9578
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	.9474
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	1.0091
Washington, MD	
Hamilton-Middletown, OH	1.0435
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	1.0356
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-New Middletown-Britain-Bristol, CT	1.0692
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.9503
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1471
Honolulu, HI	
Houma-Thibodaux, LA	.9786
Lafourche, LA	
Terrebonne, LA	
Houston, TX	1.1119
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	.9609
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.8996
Madison, AL	
Indianapolis, IN	1.0555
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.1423
Johnson, IA	
Jackson, MI	[1] 1.0281
Jackson, MI	
Jackson, MS	.9110
Hinds, MS	
Madison, MS	
Rankin, MS	
Jacksonville, FL	.9914
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	[1].8848
Onslow, NC	
Janesville-Beloit, WI	.8907
Rock, WI	
Jersey City, NJ	1.0913
Hudson, NJ	
Johnston City-Kingsport-Bristol, TN-VA	.9240
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	1.0264
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0893
Grundy, IL	
Will, IL	
Joplin, MO	.9579
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.2269
Kalamazoo, MI	
Kankakee, IL	.9143
Kankakee, IL	
Kansas City, KS	.9764
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Kansas City, MO	.9910

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	[1]1.0913
Kenosha, WI	
Killeen-Temple, TX	.9402
Bell, TX	
Coryell, TX	
Knoxville, TN	.9186
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9610
Howard, IN	
Tipton, IN	
LaCrosse, WI	[1].9402
LaCrosse, WI	
Lafayette, LA	1.0162
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	.9112
Tippecanoe, IN	
Lake Charles, LA	.9942
Calcasieu, LA	
Lake County, IL	1.1086
Lake, IL	
Lakeland-Winter Haven, FL	.9276
Polk, FL	
Lancaster, PA	1.0372
Lancaster, PA	
Lansing-East Lansing, MI	1.0514
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	[1].8561
Webb, TX	
Las Cruces, NM	[1].8455
Dona Ana, NM	
Las Vegas, NV	1.2190
Clark, NV	
Lawrence, KS	[1].9797
Douglas, KS	
Lawton, OK	[1].9278
Comanche, OH	
Lewiston-Auburn, ME	[1].9177
Androscoggin, ME	
Lexington-Fayette, KY	.9574
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	.9967
Allen, OH	
Auglaize, OH	
Lincoln, NE	.8670
Lancaster, NE	
Little Rock-North Little Rock, AR	1.0183
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	.8561
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	1.0549
Lorain, OH	
Los Angeles-Long Beach, CA	1.3037
Los Angeles, CA	
Louisville, KY-IN	1.0654
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	1.0087
Lubbock, TX	
Lynchburg, VA	.9240

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	.9650
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0259
Dane, WI	
Manchester-Nashua, NH	.9348
Hillsboro, NH	
Merrimack, NH	
Mansfield, OH	.9177
Richland, OH	
McAllen-Edinburg-Mission, TX	.8378
Hidalgo, TX	
Medford, OR	.9853
Jackson, OR	
Melbourne-Titusville-Palm Bay, FL	.9333
Brevard, FL	
Memphis, TN-AR/MS	1.0765
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Miami-Hialeah, FL	1.1492
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	1.0633
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0783
Midland, TX	
Milwaukee, WI	1.0522
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.0271
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.9330
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.0795
Stanislaus, CA	
Monmouth-Ocean, NJ	.9863
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.9550
Ouachita, LA	
Montgomery, AL	.9726
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	[1].9763
Delaware, IN	
Muskegon, MI	.9325
Muskegon, MI	
Nashville, TN	1.2287
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.2093
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9662
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.0667
New Haven, CT	
New London-Norwich, CT	[1].0667
New London, CT	
New Orleans, LA	1.0164

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3657
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.1288
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	.8741
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	.9783
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
Oakland, CA	1.2815
Alameda, CA	
Contra Costa, CA	
Ocala, FL	[1]1.0100
Marion, FL	
Odessa, TX	[1].9776
Ector, TX	
Oklahoma City, OK	1.0573
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	[1]1.0573
Thurston, WA	
Omaha, NE-IA	.8944
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	1.0061
Orange, NY	
Orlando, FL	1.0146
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	[1].8848
Daviess, KY	
Oxnard-Ventura, CA	1.1987
Ventura, CA	
Panama City, FL	[1].9077
Bay, FL	
Parkersburg-Marietta, WV-OH	.9953
Washington, OH	
Wood, WV	
Pascagoula, MS	[1]1.0139
Jackson, MS	
Pensacola, FL	.9110
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	1.1158
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.1760
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.1122

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Maricopa, AZ	
Pine Bluff, AR	[1].8774
Jefferson, AR	
Pittsburgh, PA	1.1387
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	.9815
Berkshire, MA	
Portland, ME	.9654
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1194
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	.8455
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.0919
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	.9773
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Provo-Orem, UT	.9471
Utah, UT	
Pueblo, CO	1.1600
Pueblo, CO	
Racine, WI	1.0014
Racine, WI	
Raleigh-Durham, NC	1.0139
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Reading, PA	1.0285
Berks, PA	
Redding, CA	1.0544
Shasta, CA	
Reno, NV	1.2988
Washoe, NV	
Richland-Kennewick-Pasco, WA	.9547
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.8866
Charles City Co., VA	
Chesterfield, VA	
Colonial Hieghts City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.1753
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	1.0019
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0255
Olmsted, MN	
Rochester, NY	1.0379
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0432
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.1422
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0850

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	.8606
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9876
Buchanan, MO	
St. Louis, MO-IL	1.0716
Monroe, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0580
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2763
Monterey, CA	
Salt Lake City-Ogden, UT	.9659
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.9288
Tom Green, TX	
San Antonio, TX	1.0517
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.1897
San Diego, CA	
San Francisco, CA	1.3974
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.2954
Santa Clara, CA	
Santa Barbara-Santa Maria-Lompoc, CA	1.1117
Santa Barbara, CA	
Santa Cruz, CA	1.1367
Santa Cruz, CA	
Santa Rosa-Petaluma, CA	1.1832
Sonoma, CA	
Sarasota, FL	.9880
Sarasota, FL	
Savannah, GA	.9521
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	.9762
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.0881
King, WA	
Snohomish, WA	
Sharon, PA	.9660
Mercer, PA	
Sheboygan, WI	.8857
Sheboygan, WI	
Sherman-Denison, TX	.9015
Grayson, TX	
Shreveport, LA	1.0656
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	1.0322
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	.9448
Minnehaha, SD	
South Bend-Mishawaka, IN	.8989
St. Joseph, IN	
Spokane, WA	1.1193
Spokane, WA	
Springfield, IL	1.1417
Menard, IL	
Sangamon, IL	
Springfield, MO	.9537
Christian, MO	
Greene, MO	
Springfield, MA	.9875
Hampden, MA	
Hampshire, MA	
State College, PA	[1] 1.0573
Centre, PA	
Steubenville-Weirton, OH-WV	.9763

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1647
San Joaquin, CA	
Syracuse, NY	1.4557
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0445
Pierce, WA	
Tallahassee, FL	.9270
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	.9983
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8874
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	1.1104
Miller, AR	
Bowie, TX	
Toledo, OH	1.1330
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	1.1131
Shawnee, KS	
Trenton, NJ	1.0366
Mercer, NJ	
Tucson, AZ	1.0161
Pima, AZ	
Tulsa, OK	1.0392
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	1.0186
Tuscaloosa, AL	
Tyler, TX	1.0029
Smith, TX	
Utica-Rome, NY	.9351
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.3293
Napa, CA	
Solano, CA	
Vancouver, WA	[1] 1.0829
Clark, WA	
Victoria, TX	.8634
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9498
Cumberland, NJ	
Visalia-Tulare-Portervile, CA	1.1354
Tulare, CA	
Waco, TX	.8330
McLennan, TX	
Washington, D.C.-MD-VA	1.1637
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	.9100
Black Hawk, IA	
Bremer, IA	
Wausau, WI	[1] .9315
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	.9806
Palm Beach, FL	
Wheeling, WV-OH	.9831

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

MSA area	Wage index
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.1213
Butler, KS	
Sedgwick, KS	
Wichita Falls, TX	.8718
Wichita, TX	
Williamsport, PA	1.0262
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0893
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.9015
New Hanover, NC	
Worcester-Fitchburg, Leominstar, MA	.9769
Worcester, MA	
Yakima, WA	1.0039
Yakima, WA	
York, PA	1.0307
Adams, PA	
York, PA	
Youngstown-Warren, OH	1.1040
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0829
Sutter, CA	
Yuba, CA	

[1] Approximate value for area.

TABLE 4b.—WAGE INDEX FOR RURAL AREAS

Non-MSA area	Wage Index
Alabama	.7791
Alaska	1.3768
Arizona	.8949
Arkansas	.7810
California	1.0108
Colorado	.8322
Connecticut	.9973
Delaware	.9015
Florida	.8721
Georgia	.8502
Hawaii	1.1771
Idaho	.9002
Illinois	.8683
Indiana	.8617
Iowa	.8174
Kansas	.8135
Kentucky	.8154
Louisiana	.8356
Maine	.8672
Maryland	.9315
Massachusetts	.9710
Michigan	.9475
Minnesota	.8589
Mississippi	.8020
Missouri	.8297
Montana	.8701
Nebraska	.7426
Nevada	1.0178

TABLE 4b.—WAGE INDEX FOR RURAL AREAS—Continued

Non-MSA area	Wage Index
New Hampshire	1.0318
New Jersey [1]	
New Mexico	.9293
New York	.8716
North Carolina	.8503
North Dakota	.8326
Ohio	.9145
Oklahoma	.8592
Oregon	.9562
Pennsylvania	1.0329
Rhode Island [1]	
South Carolina	.8087
South Dakota	.7873
Tennessee	.7876
Texas	.8123
Utah	.8261
Vermont	.8774
Virginia	.8519
Washington	.9498
West Virginia	.9182
Wisconsin	.8302
Wyoming	.9565

[1] All counties within the State are classified urban.

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.3548	19.4	39
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.2829	15.8	36
3	1	SURG	* CRANIOTOMY AGE <18	2.9489	12.7	33
4	1	SURG	SPINAL PROCEDURES	2.2452	16.0	36
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6780	9.8	30
6	1	SURG	CARPAL TUNNEL RELEASE	.3993	2.6	8
7	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C.	1.0279	5.3	25
8	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C.	.7239	4.1	23
9	1	MED	SPINAL DISORDERS + INJURIES	1.3958	9.1	29
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C.	1.3087	9.6	30
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	1.2545	8.5	29
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.1136	9.4	29
13	1	MED	MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA	1.0150	8.9	29
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3527	9.9	30
15	1	MED	TRANSIENT ISCHEMIC ATTACKS	.6673	5.6	24
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	.8592	7.4	27
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	.8392	7.2	27
18	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C.	.7915	6.6	27
19	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	.6975	5.7	26
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.3141	7.6	28
21	1	MED	* VIRAL MENINGITIS	.6301	4.5	15
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7869	6.4	26
23	1	MED	NONTRAUMATIC STUPOR + COMA	1.1568	5.9	26
24	1	MED	SEIZURE + HEADACHE AGE >69 AND/OR C.C.	.7279	5.6	26
25	1	MED	SEIZURE + HEADACHE AGE 18-69 W/O C.C.	.6392	4.9	25
26	1	MED	* SEIZURE + HEADACHE AGE 0-17	.4349	3.3	13
27	1	MED	* TRAUMATIC STUPOR + COMA, COMA >1 HR	1.1368	4.1	24
28	1	MED	TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C.	1.0701	5.9	26
29	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C.	.7175	3.8	24
30	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 0-17	.3576	2.0	8
31	1	MED	CONCUSSION AGE >69 AND/OR C.C.	.6051	4.6	25
32	1	MED	CONCUSSION AGE 18-69 W/O C.C.	.4519	3.3	19
33	1	MED	* CONCUSSION AGE 0-17	.2483	1.6	5
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR C.C.	.9927	7.1	27
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	.8460	6.2	26
36	2	SURG	RETINAL PROCEDURES	.7093	5.0	15
37	2	SURG	ORBITAL PROCEDURES	.5630	3.4	11
38	2	SURG	PRIMARY IRIS PROCEDURES	.4325	3.0	9
39	2	SURG	LENS PROCEDURES	.5010	2.8	6
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.3977	2.4	7
41	2	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3695	1.6	4
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS	.5906	3.8	12
43	2	MED	* HYPHEMA	.3828	4.2	12
44	2	MED	ACUTE MAJOR EYE INFECTIONS	.6258	6.5	22
45	2	MED	NEUROLOGICAL EYE DISORDERS	.5641	4.3	18

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY (UTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 WITH C.C.	.5964	4.1	23
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O C.C.	.5064	3.0	12
48	2	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.4060	2.9	13
49	3	SURG	MAJOR HEAD + NECK PROCEDURES	2.5270	13.6	34
50	3	SURG	SIALOADENECTOMY	.7160	4.6	14
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6702	4.2	15
52	3	SURG	* CLEFT LIP + PALATE REPAIR	.6488	3.8	11
53	3	SURG	SINUS + MASTOID PROCEDURES AGE >17	.5895	3.5	11
54	3	SURG	* SINUS + MASTOID PROCEDURES AGE 0-17	.6961	3.2	11
55	3	SURG	MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES	.4153	2.5	7
56	3	SURG	RHINOPLASTY	.4144	2.8	8
57	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY AGE >17	.5251	2.7	8
58	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY AGE 0-17	.3130	1.5	3
59	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17	.3147	2.0	4
60	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2643	1.5	3
61	3	SURG	* MYRINGOTOMY AGE >17	.4273	2.1	5
62	3	SURG	* MYRINGOTOMY AGE 0-17	.3121	1.3	3
63	3	SURG	OTHER EAR, NOSE + THROAT O.R. PROCEDURES	1.1090	5.8	26
64	3	MED	EAR, NOSE + THROAT MALIGNANCY	1.0812	5.7	26
65	3	MED	DYSEQUILIBRIUM	.4857	4.6	17
66	3	MED	EPISTAXIS	.4116	3.7	15
67	3	MED	* EPIGLOTTITIS	.6762	4.3	17
68	3	MED	OTITIS MEDIA + URI AGE >69 AND/OR C.C.	.6289	6.0	22
69	3	MED	OTITIS MEDIA + URI AGE 18-69 W/O C.C.	.5417	4.8	19
70	3	MED	* OTITIS MEDIA + URI AGE 0-17	.3697	3.1	10
71	3	MED	* LARYNGOTRACHEITIS	.3589	2.9	9
72	3	MED	NASAL TRAUMA + DEFORMITY	.4857	3.8	18
73	3	MED	OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17	.5217	3.5	17
74	3	MED	* OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17	.3463	2.1	8
75	4	SURG	MAJOR CHEST PROCEDURES	2.6044	14.4	34
76	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST WITH C.C.	1.8734	10.6	31
77	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST W/O C.C.	1.8178	9.5	30
78	4	MED	PULMONARY EMBOLISM	1.4095	10.4	30
79	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C.	1.7982	11.2	31
80	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C.	1.7445	10.9	31
81	4	MED	* RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17	.8743	6.1	26
82	4	MED	RESPIRATORY NEOPLASMS	1.1400	7.4	27
83	4	MED	MAJOR CHEST TRAUMA AGE >69 AND/OR C.C.	.9809	8.1	28
84	4	MED	* MAJOR CHEST TRAUMA AGE <70 W/O C.C.	.7738	5.3	22
85	4	MED	PLEURAL EFFUSION AGE >69 AND/OR C.C.	1.1461	8.4	28
86	4	MED	PLEURAL EFFUSION AGE <70 W/O C.C.	1.1217	7.6	28
87	4	MED	PULMONARY EDEMA + RESPIRATORY FAILURE	1.5529	7.7	28
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0412	7.5	28
89	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C.	1.1029	8.5	29
90	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C.	.9849	7.6	28

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

TABLE 5 Page 3 of 11

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
91	4	MED	* SIMPLE PNEUMONIA + PLEURISY AGE 0-17	.5131	4.6	14
92	4	MED	INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C.	1.0370	7.8	28
93	4	MED	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	.9724	6.9	27
94	4	MED	PNEUMOTHORAX AGE >69 AND/OR C.C.	1.4374	9.2	29
95	4	MED	PNEUMOTHORAX AGE <70 W/O C.C.	1.1252	7.7	28
96	4	MED	BRONCHITIS + ASTHMA AGE >69 AND/OR C.C.	.7996	6.9	24
97	4	MED	BRONCHITIS + ASTHMA AGE 18-69 W/O C.C.	.7256	6.2	21
98	4	MED	* BRONCHITIS + ASTHMA AGE 0-17	.4275	3.7	11
99	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.8035	5.5	26
100	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C.	.7730	5.1	24
101	4	MED	OTHER RESPIRATORY DIAGNOSES AGE >69 AND/OR C.C.	.9035	6.8	27
102	4	MED	OTHER RESPIRATORY DIAGNOSES AGE <70	.9024	6.1	26
103	5	SURG	* HEART TRANSPLANT	.0000	.0	0
104	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH	6.8527	20.9	41
105	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH	5.2308	16.2	36
106	5	SURG	** CORONARY BYPASS WITH CARDIAC CATH	5.2624	20.4	40
107	5	SURG	** CORONARY BYPASS W/O CARDIAC CATH	3.9891	13.5	34
108	5	SURG	CARDIOTHOR PROC,EXCEPT VALVE + CORONARY BYPASS,WITH PUMP	4.3756	13.3	33
109	5	SURG	CARDIOTHORACIC PROCEDURES W/O PUMP	3.6963	12.1	32
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE >69 AND/OR C.C.	2.9328	14.3	34
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE <70 W/O C.C.	2.5851	13.2	33
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION	2.3500	11.2	31
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE	2.6800	21.6	42
114	5	SURG	UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.1067	16.6	37
115	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI OR CHF	3.9150	15.8	36
116	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	2.8665	9.3	29
117	5	SURG	CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY	1.8210	6.4	26
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.7809	4.2	18
119	5	SURG	VEIN LIGATION + STRIPPING	1.0610	7.2	27
120	5	SURG	OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.5204	15.0	35
121	5	MED	** CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE	1.8648	11.9	32
122	5	MED	** CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3651	9.8	30
123	5	MED	CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.1360	3.1	23
124	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG	2.2200	8.4	28
125	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	1.6455	5.0	25
126	5	MED	ACUTE + SUBACUTE ENDOCARDITIS	2.6645	18.4	38
127	5	MED	HEART FAILURE + SHOCK	1.0408	7.8	28
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	.8639	9.6	28
129	5	MED	CARDIAC ARREST	1.5506	4.6	25
130	5	MED	PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C.	.9645	7.1	27
131	5	MED	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	.9451	6.4	26
132	5	MED	ATHEROSCLEROSIS AGE >69 AND/OR C.C.	.9182	6.7	27
133	5	MED	ATHEROSCLEROSIS AGE <70 W/O C.C.	.8599	5.2	25
134	5	MED	HYPERTENSION	.7049	6.1	26
135	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C.	.9922	6.1	26

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
136	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C.	.9674	4.9	25
137	5	MED	* CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 0-17	.6381	3.3	20
138	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE >69 AND/OR C.C.	.9297	5.7	26
139	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C.	.8303	4.8	23
140	5	MED	ANGINA PECTORIS	.7548	5.5	21
141	5	MED	SYNCOPE + COLLAPSE AGE >69 AND/OR C.C.	.6475	5.0	21
142	5	MED	SYNCOPE + COLLAPSE AGE <70 W/O C.C.	.5680	4.3	18
143	5	MED	CHEST PAIN	.6814	4.4	19
144	5	MED	OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.1267	7.0	27
145	5	MED	OTHER CIRCULATORY DIAGNOSES W/O C.C.	1.0020	6.4	26
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR C.C.	2.7082	19.1	39
147	6	SURG	RECTAL RESECTION AGE <70 W/O C.C.	2.5087	17.9	38
148	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	2.5493	17.0	37
149	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.2154	15.2	35
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C.	2.3746	15.3	35
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	2.0274	13.4	33
152	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	1.4851	10.6	31
153	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.2599	9.3	29
154	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C.	2.6901	14.8	35
155	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.3336	13.0	33
156	6	SURG	* STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17	.8470	6.0	20
157	6	SURG	ANAL PROCEDURES AGE >69 AND/OR C.C.	.7985	6.0	25
158	6	SURG	ANAL PROCEDURES AGE <70 W/O C.C.	.6408	5.2	19
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C.	.9297	7.1	23
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C.	.7676	6.0	18
161	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C.	.7068	5.7	16
162	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	.5854	4.8	12
163	6	SURG	* HERNIA PROCEDURES AGE 0-17	.4358	2.1	6
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C.	1.8320	11.9	32
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.6154	11.3	29
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C.	1.4328	9.4	29
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.0818	7.4	22
168	6	SURG	PROCEDURES ON THE MOUTH AGE >69 AND/OR C.C.	.8631	4.3	24
169	6	SURG	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	.8992	4.2	24
170	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE >69 AND/OR C.C.	2.6602	14.6	35
171	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE <70 W/O C.C.	2.3976	13.3	33
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C.	1.2268	8.2	28
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0517	6.7	27
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR C.C.	.9281	6.7	27
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O C.C.	.8236	5.8	24
176	6	MED	COMPLICATED PEPTIC ULCER	1.2438	8.1	28
177	6	MED	UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C.	.7422	6.6	24
178	6	MED	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	.6141	5.5	20
179	6	MED	INFLAMMATORY BOWEL DISEASE	1.0153	8.0	28
180	6	MED	G.I. OBSTRUCTION AGE >69 AND/OR C.C.	.8197	6.2	26

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
181	6	MED	G.I. OBSTRUCTION AGE <70 W/O C.C.	.7845	5.9	26
182	6	MED	ESOPHAGITIS,GASTRCENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C.	.6185	5.4	22
183	6	MED	ESOPHAGITIS,GASTRCENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C.	.5652	4.8	19
184	6	MED	* ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17	.3822	3.3	11
185	6	MED	DENTAL + CRAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17	.6681	4.2	24
186	6	MED	* DENTAL + CRAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17	.4155	2.9	11
187	6	MED	DENTAL EXTRACTIONS + RESTORATIONS	.3990	2.7	8
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.7444	5.1	25
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	.6576	4.5	23
190	6	MED	* OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.3379	2.1	8
191	7	SURG	MAJOR PANCREAS, LIVER + SHUNT PROCEDURES	4.1791	20.8	41
192	7	SURG	* MINOR PANCREAS, LIVER + SHUNT PROCEDURES	3.9197	20.1	40
193	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C.	2.4513	17.3	37
194	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	1.9881	13.9	34
195	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C.	2.1690	16.8	36
196	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	2.0594	15.8	36
197	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C.	1.4868	11.5	29
198	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.2752	10.1	24
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4574	17.9	38
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.5818	15.1	35
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7291	16.9	37
202	7	MED	CIRRHOSIS + ALCOHOLIC HEPATITIS	1.1965	9.3	29
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0937	8.0	28
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9682	7.5	28
205	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C.	1.0822	7.9	28
206	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	.9247	6.8	27
207	7	MED	DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C.	.8492	6.6	27
208	7	MED	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	.7315	5.5	24
209	8	SURG	MAJOR JOINT PROCEDURES	2.2912	17.1	37
210	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C.	2.0833	17.8	38
211	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9530	15.9	36
212	8	SURG	* HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.7132	11.1	31
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS	2.1315	14.3	34
214	8	SURG	BACK + NECK PROCEDURES AGE >69 AND/OR C.C.	1.8427	15.6	36
215	8	SURG	BACK + NECK PROCEDURES AGE <70 W/O C.C.	1.4920	13.8	33
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.5596	11.3	31
217	8	SURG	WND DEBRIC + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS	2.2824	13.1	33
218	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C.	1.4250	10.9	31
219	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0790	8.3	27
220	8	SURG	* LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9339	5.3	25
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR C.C.	1.2727	8.3	28
222	8	SURG	KNEE PROCEDURES AGE <70 W/O C.C.	.9897	6.4	26
223	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C.	1.0723	6.9	27
224	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C.	.8952	5.6	24
225	8	SURG	FOOT PROCEDURES	.6476	4.8	15

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DRG	MDC	TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
226	8 SURG	SOFT TISSUE PROCEDURES AGE >69 AND/OR C.C.	.7984	5.1	25
227	8 SURG	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	.6337	4.2	18
228	8 SURG	GANGLION (HAND) PROCEDURES	.3626	2.2	7
229	8 SURG	HAND PROCEDURES EXCEPT GANGLION	.5998	3.4	14
230	8 SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR	1.3594	8.9	29
231	8 SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR	.9519	5.3	25
232	8 SURG	ARTHROSCOPY	.6063	3.6	15
233	8 SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C.	1.7737	13.1	33
234	8 SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C.	1.2454	8.2	28
235	8 MED	FRACTURES OF FEMUR	1.7586	13.6	34
236	8 MED	FRACTURES OF HIP + PELVIS	1.3855	11.9	32
237	8 MED	SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH	.7929	6.4	26
238	8 MED	OSTEOMYELITIS	1.5511	12.3	32
239	8 MED	PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY	1.0979	9.2	29
240	8 MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C.	.9709	8.6	29
241	8 MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	.9048	8.0	28
242	8 MED	SEPTIC ARTHRITIS	1.5880	11.2	31
243	8 MED	MEDICAL BACK PROBLEMS	.7551	7.5	28
244	8 MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE >69 AND/OR C.C.	.7792	7.5	28
245	8 MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE <70 W/O C.C.	.7177	6.3	26
246	8 MED	NON-SPECIFIC ARTHROPATHIES	.7147	6.8	27
247	8 MED	SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE	.6559	5.8	26
248	8 MED	TENDONITIS, MYOSITIS + BURSITIS	.6136	5.4	24
249	8 MED	AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.0203	7.6	28
250	8 MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C.	.7428	6.0	26
251	8 MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	.5964	4.2	24
252	8 MED	* FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 0-17	.3533	1.8	7
253	8 MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE >69 +/OR C.C.	.7466	6.6	27
254	8 MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	.6258	5.3	25
255	8 MED	* FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4687	2.9	15
256	8 MED	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.8706	6.5	27
257	9 SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.1085	9.3	23
258	9 SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0729	8.9	21
259	9 SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0141	7.4	27
260	9 SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70	.9325	6.4	26
261	9 SURG	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC	.7329	4.8	19
262	9 SURG	BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY	.4617	3.0	10
263	9 SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE >69 AND/OR C.C.	2.4737	21.3	41
264	9 SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE <70 W/O C.C.	2.2031	18.2	38
265	9 SURG	* SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS WITH C.C.	1.4959	8.6	29
266	9 SURG	SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS W/O C.C.	.9485	5.9	26
267	9 SURG	PERIANAL + PILONIDAL PROCEDURES	.6113	5.0	18
268	9 SURG	SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES	.5388	3.0	15
269	9 SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C.	.9947	5.7	26
270	9 SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C.	.8123	4.5	25

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
271	9	MED	SKIN ULCERS	1.3802	12.1	32
272	9	MED	MAJOR SKIN DISORDERS AGE >69 AND/OR C.C.	.8620	7.8	28
273	9	MED	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	.8286	7.3	27
274	9	MED	MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C.	1.0108	7.5	28
275	9	MED	MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	.9014	6.4	26
276	9	MED	NON-MALIGANT BREAST DISORDERS	.6066	4.2	22
277	9	MED	CELLULITIS AGE >69 AND/OR C.C.	.8863	8.3	28
278	9	MED	CELLLLITIS AGE 18-69 W/O C.C.	.8096	7.2	27
279	9	MED	* CELLULITIS AGE 0-17	.4789	4.2	13
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE >69 +/OR C.C.	.6201	5.4	25
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C.	.5377	4.2	23
282	9	MED	* TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 0-17	.3460	2.2	9
283	9	MED	MINOR SKIN DISORDERS AGE >69 AND/OR C.C.	.6394	5.3	25
284	9	MED	MINOR SKIN DISORDERS AGE <70 W/O C.C.	.5971	4.4	24
285	10	SURG	AMPUTATIONS FOR ENDOCRINE,NUTRITIONAL + METABOLIC DISORDERS	2.8658	24.0	44
286	10	SURG	* ADRENAL + PITUITARY PROCEDURES	2.8952	16.1	36
287	10	SURG	SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS	2.8143	22.8	43
288	10	SURG	* C.R. PROCEDURES FOR OBESITY	1.5695	10.0	24
289	10	SURG	PARATHYROID PROCEDURES	1.3736	8.3	28
290	10	SURG	THYROID PROCEDURES	.8549	6.0	17
291	10	SURG	* THYROGLOSSAL PROCEDURES	.4909	2.9	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE >69 +/OR C.C.	2.0307	10.8	31
293	10	SURG	* OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C.	1.4951	8.0	28
294	10	MED	DIABETES AGE =>36	.8087	7.7	28
295	10	MED	DIABETES AGE 0-35	.7457	5.6	26
296	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C.	.8979	7.3	27
297	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	.7923	6.0	26
298	10	MED	* NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17	.7538	5.4	25
299	10	MED	INBORN ERRORS OF METABOLISM	.9407	6.8	27
300	10	MED	ENDOCRINE DISORDERS AGE >69 AND/OR C.C.	.9731	7.8	28
301	10	MED	ENDOCRINE DISORDERS AGE <70 W/O C.C.	.8143	6.4	26
302	11	SURG	KIDNEY TRANSPLANT	6.6322	24.1	44
303	11	SURG	KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.5397	16.2	36
304	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE >69 +/OR C.C.	1.7952	12.8	33
305	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE <70 W/O C.C.	1.7043	11.9	32
306	11	SURG	PROSTATECTOMY AGE >69 AND/OR C.C.	1.1399	8.6	29
307	11	SURG	PROSTATECTOMY AGE <70 W/O C.C.	.9513	7.2	26
308	11	SURG	MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C.	1.0441	7.1	27
309	11	SURG	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	.9290	5.7	26
310	11	SURG	TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C.	.7071	4.9	20
311	11	SURG	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	.5871	4.1	15
312	11	SURG	URETHRAL PROCEDURES, AGE >69 AND/OR C.C.	.7424	5.2	22
313	11	SURG	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	.6857	5.1	21
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4368	2.3	11
315	11	SURG	OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES	2.4884	9.8	30

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
316	11	MED	RENAL FAILURE W/O DIALYSIS	1.3314	6.7	27
317	11	MED	* RENAL FAILURE WITH DIALYSIS	.2385	1.2	3
318	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C.	.9142	5.5	26
319	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	.7942	4.2	24
320	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C.	.8123	7.0	27
321	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/C C.C.	.6803	5.6	23
322	11	MED	* KIDNEY + URINARY TRACT INFECTIONS AGE 0-17	.4553	3.7	13
323	11	MED	URINARY STONES AGE >69 AND/OR C.C.	.7131	4.9	25
324	11	MED	URINARY STONES AGE <70 W/O C.C.	.5472	3.9	19
325	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7247	5.4	25
326	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C.	.5875	4.3	21
327	11	MED	* KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17	.5027	3.1	14
328	11	MED	URETHRAL STRICTURE AGE >69 AND/OR C.C.	.6508	4.8	22
329	11	MED	URETHRAL STRICTURE AGE 18-69 W/O C.C.	.5326	3.9	17
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2817	1.6	5
331	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE >69 AND/OR C.C.	.8919	6.3	26
332	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	.7763	5.8	25
333	11	MED	* OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17	.5146	3.2	18
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH C.C.	1.5612	12.7	38
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.3590	11.8	29
336	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C.	1.0079	8.4	22
337	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	.8491	7.2	17
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.9069	6.3	26
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANT AGE >17	.6093	4.5	15
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4381	2.4	7
341	12	SURG	PENIS PROCEDURES	.9983	6.0	23
342	12	SURG	CIRCUMCISION AGE >17	.4228	2.8	10
343	12	SURG	* CIRCUMCISION AGE 0-17	.3828	1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1204	7.4	27
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8334	5.6	26
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C.	.9395	6.9	27
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/C C.C.	.8304	5.7	26
348	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C.	.8864	6.2	26
349	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	.6998	4.9	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6096	5.2	20
351	12	MED	* STERILIZATION, MALE	.2655	1.3	3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6385	4.4	20
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY	1.9376	12.4	32
354	13	SURG	NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C.	1.1108	9.6	20
355	13	SURG	NON-RADICAL HYSTERECTOMY AGE <70 W/C C.C.	1.0156	8.8	17
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8460	8.1	18
357	13	SURG	UTERUS + ADNEXA PROCEDURES, FOR MALIGNANCY	1.9188	13.9	34
358	13	SURG	UTERUS + ADNEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT	1.0890	8.0	28
359	13	SURG	* TUBAL INTERRUPTION FOR NON-MALIGNANCY	.4279	2.3	7
360	13	SURG	VAGINA, CERVIX + VULVA PROCEDURES	.5985	4.2	19

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
361	13	SURG	* LAPAROSCOPY & ENDOSCOPY (FEMALE) EXCEPT TUBAL INTERRUPTION	.4864	2.6	10
362	13	SURG	* LAPAROSCOPIC TUBAL INTERRUPTION	.3126	1.4	5
363	13	SURG	D&C,CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6516	4.3	18
364	13	SURG	D&C,CONIZATION EXCEPT FOR MALIGNANCY	.4028	2.6	9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7965	12.7	33
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C.	.8444	5.2	25
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	.5786	3.5	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7944	6.7	27
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.6959	5.1	25
370	14	SURG	* CESAREAN SECTION WITH C.C.	.9912	7.6	15
371	14	SURG	* CESAREAN SECTION W/O C.C.	.7535	6.1	10
372	14	MED	* VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5534	3.8	9
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4063	3.2	9
374	14	SURG	* VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C	.5492	3.6	7
375	14	SURG	* VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D&C	.6889	4.4	15
376	14	MED	* POSTPARTUM DIAGNOSES W/O O.R. PROCEDURE	.4158	2.9	10
377	14	SURG	* POSTPARTUM DIAGNOSES WITH O.R. PROCEDURE	.4761	2.2	8
378	14	MED	* ECTOPIC PREGNANCY	.8094	5.5	11
379	14	MED	* THREATENED ABORTION	.3169	2.2	8
380	14	MED	* ABORTION W/O D&C	.2705	1.5	4
381	14	MED	* ABORTION WITH D&C	.3602	1.4	4
382	14	MED	* FALSE LABOR	.1842	1.2	2
383	14	MED	* OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4317	3.4	14
384	14	MED	* OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3245	2.2	9
385	15		* NEONATES, DIED OR TRANSFERRED	.6883	1.8	14
386	15		* EXTREME IMMATURITY, NEONATE	3.6863	17.9	38
387	15		** PREMATURITY WITH MAJOR PROBLEMS	1.8459	13.3	33
388	15		** PREMATURITY W/O MAJOR PROBLEMS	1.1693	8.6	29
389	15		* FULL TERM NEONATE WITH MAJOR PROBLEMS	.5482	4.7	16
390	15		* NEONATES WITH OTHER SIGNIFICANT PROBLEMS	.3523	3.4	9
391	15		* NORMAL NEWBORNS	.2241	3.1	7
392	16	SURG	SPLENECTOMY AGE >17	2.7746	16.4	36
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5366	9.1	29
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.1146	6.1	26
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7839	6.1	26
396	16	MED	* RED BLOOD CELL DISORDERS AGE 0-17	.6295	4.1	18
397	16	MED	COAGULATION DISORDERS	.9863	6.7	27
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >69 AND/OR C.C.	.8900	6.1	26
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C.	.8459	5.6	26
400	17	SURG	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.8272	16.9	37
401	17	SURG	LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROC AGE >69 AND/OR C.C.	1.2409	8.9	29
402	17	SURG	* LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROCEDURE AGE <70 W/O C.C.	1.1316	7.1	27
403	17	MED	LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C.	1.1715	7.1	27
404	17	MED	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	1.1787	6.4	26
405	17	MED	* LYMPHOMA OR LEUKEMIA AGE 0-17	1.0517	4.9	25

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC + C.C.	2.2671	15.0	35
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	2.1366	13.3	33
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH MINOR O.R.PROC	1.1389	7.1	27
409	17	MED	* RADIOTHERAPY	.8134	5.7	26
410	17	MED	CHEMOTHERAPY	.3527	2.6	12
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.7221	4.7	25
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3480	2.0	8
413	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>69 +/OR C.C	1.0975	7.3	27
414	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	1.0359	6.4	26
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS + PARASITIC DISEASES	3.0027	15.1	35
416	18	MED	SEPTICEMIA AGE >17	1.5504	9.2	29
417	18	MED	* SEPTICEMIA AGE 0-17	.7152	5.2	20
418	18	MED	POSTOPERATIVE + POST-TRAUMATIC INFECTIONS	.9968	8.4	28
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C.	.8628	6.9	27
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	.8022	6.2	26
421	18	MED	VIRAL ILLNESS AGE >17	.6045	5.4	21
422	18	MED	* VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17	.4360	3.2	10
423	18	MED	OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES	1.2107	8.8	29
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.1938	14.2	34
425	19	MED	ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6812	5.8	26
426	19	MED	DEPRESSIVE NEUROSES	.9495	9.4	29
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7678	6.9	27
428	19	MED	DISORDERS OF PERSONALITY + IMPULSE CONTROL	.9741	8.3	28
429	19	MED	ORGANIC DISTURBANCES + MENTAL RETARDATION	.9523	8.8	29
430	19	MED	PSYCHOSES	1.0934	10.8	31
431	19	MED	* CHILDHOOD MENTAL DISORDERS	2.2519	15.4	35
432	19	MED	* OTHER DIAGNOSES OF MENTAL DISORDERS	1.0525	7.2	27
433	20		** SUBSTANCE USE + SUBST INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.4457	2.5	17
434	20		** DRUG DEPENDENCE	1.0404	9.1	29
435	20		** DRUG USE EXCEPT DEPENDENCE	1.0738	8.0	28
436	20		** ALCOHOL DEPENDENCE	.8853	8.1	28
437	20		** ALCOHOL USE EXCEPT DEPENDENCE	.6183	3.5	24
438	20		** ALCOHOL + SUBSTANCE INDUCED ORGANIC MENTAL SYNDROME	.8420	6.9	27
439	21	SURG	* SKIN GRAFTS FOR INJURIES	1.8219	8.9	29
440	21	SURG	* WOUND DEBRIDEMENTS FOR INJURIES	1.4807	7.2	27
441	21	SURG	* HAND PROCEDURES FOR INJURIES	.7180	3.0	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C.	1.9026	9.1	29
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.5211	6.6	27
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR C.C.	.8830	6.7	27
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	.7530	5.2	25
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4846	2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4785	3.7	15
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3505	2.9	8
449	21	MED	TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C.	.7331	5.6	26
450	21	MED	TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	.5957	3.9	23

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER CUTOFFS
451	21	MED	* TOXIC EFFECTS OF DRUGS AGE 0-17	.2912	2.1	8
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C.	.8492	5.5	26
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	.9020	5.1	25
454	21	MED	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE >69 AND/OR C.C.	.8224	5.3	25
455	21	MED	* OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE <70 W/O C.C.	.6185	3.5	22
456	22		** BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	2.0902	11.6	32
457	22		** EXTENSIVE BURNS	6.8631	12.6	33
458	22	SURG	** NON-EXTENSIVE BURNS WITH SKIN GRAFTS	2.8572	18.3	38
459	22	SURG	** NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT & OTHER O.R. PROC	2.7568	12.7	33
460	22	MED	** NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.4225	9.0	29
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.6507	8.0	28
462	23	MED	* REHABILITATION	1.8268	13.5	34
463	23	MED	SIGNS & SYMPTOMS WITH C.C.	.7702	6.3	26
464	23	MED	SIGNS & SYMPTOMS W/O C.C.	.7322	6.0	26
465	23	MED	** AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2071	1.5	4
466	23	MED	** AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.6377	3.7	24
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.9799	6.1	26
468			UNRELATED OR PROCEDURE	2.1037	11.2	31
469			***PDX INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470			***UNGROUPABLE	.0000	.0	0

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VIII. Technical Explanation of the Budget Neutrality Adjustment Methodology

A. *Overview*

Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

In determining the amount of the budget neutrality adjustment factors, we have considered all hospital costs, including pass-through costs such as capital-related and direct medical education costs. However, it should be noted that the *aggregate payments* that will be adjusted to be budget neutral do not include payment for capital-related costs or direct medical education costs, payments for hospital and distinct part unit services excluded from the prospective payment system, payment of a return on equity capital, or payments on a reasonable cost basis to hospitals under the prospective payment system for outpatient services.

The budget neutrality adjustments required by the statute are determined by comparing an estimate of fiscal year 1984 reimbursement per discharge, under the law in effect prior to enactment of Pub. L. 98–21, with an estimate of DRG-related payments per discharge (Federal rates, outlier payments, and payments for the indirect costs of medical education, before budget neutral adjustment) and with an estimate of the hospital-specific payments per discharge (before budget neutral adjustment). Therefore, payment under each of the three systems (reasonable cost reimbursement, Federal rates, and hospital-specific rates) must be estimated separately.

Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

Based on the estimates of projected payments under all three systems, we must derive two budget neutrality adjustment factors for Federal fiscal year 1984. The first such factor will be applied in computing Federal regional rates for cost reporting periods beginning during Federal fiscal year 1984. The second budget neutrality adjustment factor will be applied in computing the updating factors used to determine the hospital-specific portion of transition payment rates for cost reporting periods beginning during that fiscal year.

B. *Assumptions and Data*

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, we have assumed that the number of admissions under both prior law and the prospective payment system will be the same. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions.

A hospital will begin receiving payment under the prospective payment system at the beginning of its first cost reporting period starting on or after October 1, 1983. Therefore, most hospitals will not be under the prospective payment system for the entire Federal fiscal year 1984. Hence, the payment per discharge under each of the systems should be estimated only for those portions of hospital cost reporting periods beginning October 1, 1983 or later that overlap Federal fiscal year 1984. To properly compute payment per discharge, total payment is divided by the number of discharges across all hospitals. We developed a distribution of discharges that occur between the start of a hospital's cost reporting period (that starts in Federal fiscal year 1984) and September 30, 1984. This distribution, which was developed from the March 1983 update of the 1982 discharge notice file, was applied to the number of discharges in the hospital's 1981 data. This procedure properly weights the relative sizes of hospitals and cost reporting period distributions for computing payments per discharge.

Since the prospective payment system is to be budget neutral for included hospitals, and since the prospective payment system will not change payments to hospitals that are excluded from that system, excluded hospitals were removed from the determinations (for example, long term care, psychiatric, and children's hospitals). Further, four States (Maryland, Massachusetts, New Jersey, and New York) currently operate alternative reimbursment systems under Medicare waivers. Since payment amounts in these States will not change because of the prospective payment system, hospitals in these States were removed from the determination of payment per discharge under each of the three systems for purposes of determining budget neutrality.

We also assumed that the means of affording exceptions or special treatment for sole community hospitals under different systems would provide comparable relief to those relatively few hospitals that qualify for such exceptions and treatment. Since the amounts of special payments to these hospitals are assumed to be the same under the different systems, the budget neutrality determination is not affected by these payments. Therefore, we did not make explicit allowance for additional payments to these hospitals in our estimates and comparisons.

Section 1881(e)(1) of the Act requires that total payments under the DRG system and under the HSP system be the same as total payments that would have been payable under provisions of the prior law (that is, for fiscal year 1984, the limits that would have been implemented under provisions of TEFRA). To achieve this we have equalized the amounts payable under the Federal rate and HSP systems with those that would have been payable on a periodic basis under TEFRA, not with

the total end-of-year cash amounts. As a result, changes of cash flow, timing of payments, and retroactive payments will not affect the budget neutrality determination.

Operating costs are defined differently under the different systems. We excluded malpractice costs and kidney acquisition costs from operating costs under the TEFRA limits. However, the Federal rate and HSP systems exclude the same kidney acquisition costs but include malpractice costs under operating costs. We must use a method of comparing costs that takes into account "the payment amounts which would have been payable for such services for those same hospitals", as required by law. If we were to compare only the operating costs of the different payment systems we would not fulfill the statutory requirement, since the actual amounts paid are comparable only if we include both operating and nonoperating costs. Hence, nonoperating costs (excluding payments to proprietary hospitals for a return on equity capital) must also be included in the calculation of the budget neutrality adjustment factors. By using total costs, including nonoperating costs, in the comparisons necessary to determine budget neutrality adjustments, we will ensure that the amounts considered under the Federal and hospital-specific rate systems are comparable to amounts payable under prior law.

These comparisons will yield adjustments reflecting differences between the systems in a way that prevents distortions by differing definitions of operating costs. The equations below illustrate that comparing total costs in determining budget neutrality adjustments produces results identical to those that would have been produced using only operating costs under the Federal rate system and comparable costs under the TEFRA system.

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Cost Components under Federal rate and TEFRA systems

Federal rate x budget neutral factor	=	TEFRA operating costs + Malpractice costs
Federal rate x budget neutral factor + (kidney acquisition costs + capital costs + direct medical education costs)	=	TEFRA operating costs + (Malpractice costs + capital costs + kidney acquisition costs + direct medical education costs)
Federal rate x budget neutral factor + Federal system nonoperating costs	=	TEFRA operating costs + TEFRA nonoperating costs

The analysis is identical for the hospital-specific rate system. Note that payments for a return on equity (which are not classified as operating costs) are excluded from the equations. Since the amounts for return on equity differ among the systems, adding in return on equity would unbalance the equations. (Under prior law, which must be reflected in the TEFRA estimates, the rate of return was set at 1.5 times the Hospital Insurance Trust Fund interest rates, whereas under Pub. L. 98–21 the rate of return applicable to the costs related to inpatient hospital services was reduced to 1.0 times that rate.)

C. *Estimated Payment Per Discharge Under Prior Law (TEFRA Limits)*

To estimate payment per discharge under prior law, the TEFRA limits that would have been published must first be determined. These limits are calculated in the same manner as the fiscal year 1983 limits, except that the most recent data available (that is, 1981 cost report and billing data) are used, and the fiscal year 1984 limit is set at 115 percent of the mean, instead of 120 percent of the mean, in accordance with section 1886(a)(1)(A)(ii) of the Act.

To estimate payment per discharge under the TEFRA limits, cost per discharge must be estimated for each hospital and compared to the costs allowable under the TEFRA limits, that is, DRG-adjusted cost per case limits on inpatient operating costs and the separate limit on the rate of increase of those costs. Since the rate of increase target rate percentage is less than the average rate of increase in hospital costs, comparison of the rate of increase target rate percentage to the average rate of increase in hospital costs would lead to the conclusion that all hospitals would be penalized by the rate of increase limit and that no hospital would receive a bonus. (Under section 1886(b)(1) of the Act, a hospital that has per case costs less than its target amount would be paid a bonus of 50 percent of the amount by which the target amount exceeds its cost, or five percent of its target amount, whichever is less. Alternatively, a hospital that has costs in excess of its target amount would, for cost reporting periods beginning in Federal fiscal years 1983 or 1984, be paid only 25 percent of its costs in excess of the target amount.) To overcome this erroneous conclusion, the rate of increase target must be compared to cost increases that vary by hospital.

Hospital cost per discharge data for cost report years 1978, 1979, 1980, and 1981 were analyzed for patterns in rates of increase in costs per discharge. Study found that the statistical distributions of rates of increase in cost per discharge closely fit the normal distribution. Since the second year of TEFRA uses a two-year rate of increase target over the hospital's base year, we analyzed two-year rates of increase and found that a normal distribution with a standard deviation of 12 percent closely approximated the distributions. To compute a hospital's cost per discharge for comparison to the hospital's TEFRA rate-of-increase target amount, the hospital's base year costs were increased by a randomly determined factor. This factor was computed by adding the estimated two-year average rate of increase in cost per case to a random number. This random number is generated from a statistical distribution that is normal with a mean of zero, and has a standard deviation of 12 percent. Further, the random numbers were restricted so that none were further than three standard deviations from the mean. This randomly determined cost per admission for a hospital was compared to the rate of increase limit target amount for determining the reimbursement per discharge under TEFRA. Because of the randomizing process, not all hospitals are shown to be penalized by the targets; hospitals with cost per case over the target amount are shown as receiving one quarter of their excess costs over that limit (in accordance with section 1886(b) of the Act), and some hospitals are shown to receive bonus payments. To measure the overall stability, the model was tested with ten different sets of random numbers and found to be stable.

The cost per discharge that is compared to the TEFRA limits was adjusted by 0.1326 percent before

comparison to the TEFRA limits to account for the shift of certain types of costs to Part A of Medicare because of the regulations on payment for physicians' services to patients and providers, published March 2, 1983. (These rules implement section 1887 of the Act, established by section 108 of TEFRA. (48 FR 8902; 42 CFR 405.480 through 405.482, and 405.550 through 405.556.)) Since this adjustment increases the costs of hospitals below the limits, it will have the effect of raising slightly the estimate on TEFRA payment per discharge.

D. *Estimated Payment on a Federal Rate (DRG) Basis*

The estimated payment per discharge based on DRG-related payments (that is, Federal rates plus outlier payments) was estimated by directly using the adjusted average standardized amounts, adjusted by the applicable wage index, cost of living adjustment (for hospitals in Alaska and Hawaii), and case mix for each hospital. Additional outlier payments were computed using each hospital's historical experience in the MEDPAR file. The payment amounts were further adjusted to include the indirect costs of medical education.

Before the ratio of estimated DRG-related payments to the estimated payments under prior law is computed, the estimated DRG-related payment was increased by 3.38 percent to reflect improvements and greater completeness in the coding of diagnoses and procedures on the bills. This adjustment is necessary because payment will depend on the diagnoses and procedures coded on the bill, and hospitals will have the incentive to be more complete than in the past in reporting diagnoses and procedures.

Hospitals reported diagnoses on the bills that are included in the 1981 MEDPAR data. For a variety of reasons, these diagnoses were not always completely or accurately coded, especially when payment did not depend on the diagnoses coded. Since payments under the prospective system depend on the diagnoses and procedures coded, hospitals will submit complete and accurate data. We studied the differences between bills coded for the MEDPAR and bills coded after medical review. The carefully and completely coded bills were provided from the PSRO Uniform Hospital Discharge Data Set (UHDDS) data base. The data base included about 9 million bills from all States except Nebraska and Texas. The study found that reimbursement under the prospective system using the PSRO data would be 3.38 percent higher than reimbursement using the MEDPAR Data. Since the prospective rates are set using the MEDPAR data, actual reimbursement under the prospective system will be higher than predicted from the MEDPAR data; hence, the factor (3.38 percent) for improvements in diagnostic coding must be used for the budget neutral calculation.

E. *Estimated Hospital-Specific (HSP) Payment Per Discharge*

To properly estimate the payments per discharge based on the hospital-specific rates to be used during the transition period, the hospital's base year cost per case must first be estimated, since actual base year data are not available. To estimate the base year, the 1981 cost report data were adjusted by the change in the nursing differential from 1981 to the base year. These data were updated to the base year and the resulting routine operating costs were compared with the appropriate routine cost limit applicable to base year cost reporting periods, as calculated from the September 30, 1981 **Federal Register** notice, to compute the savings resulting from application of the routine cost limits. Total costs were also reduced by the remainder of the amounts based on the Medicare nursing differential, since section 103 of TEFRA, by amending section 1861(v)(1)(J) of the Act, eliminated this differential effective with services furnished on or after October 1, 1982.

Operating costs were computed by carving out of total costs direct medical education, capital-related, and certain kidney acquisition costs. Operating costs were increased by 0.18 percent and 0.13 percent to adjust, respectively, for the extra estimated costs hospitals will report for their base year because of required coverage of their employees under FICA (as required by section 1886(b)(6) of the Act) and for the requirement that certain services are now required to be paid under Part A of Medicare which were formerly paid under Part B (as required by section 1886(b)(5)(D) of the Act). Operating costs were further increased by 0.1326 percent to account for the shift of certain types of costs to Part A of Medicare because of regulations on payment for physicians' services to patients and providers, published March 2, 1983. (Those rules implement section 1887 of the Act, established by section 108 of TEFRA (48 FR 8902; 42 CFR 405.480 through 405.482, and 405.550 through 405.556.)) The base year operating costs were increased by two years of the market basket index increased by one percentage point for each year. This result was further increased by 3.38 percent to allow for improvements and greater completeness in the coding of diagnoses and procedures. This adjustment, discussed above under the Federal rate system, is necessary because the hospital-specific portion will be adjusted by the DRG weighting factors.

F. Adjustment for Outlier Payments

Sections 1886(d)(2)(E) and (d)(3)(B) of the Act require that the average standardized amounts for the Federal rates be reduced so that, when combined with the outlier payments, the resulting payments will be the same as payments under a DRG-related system with no outlier payments but full standard DRG-adjusted rates.

For cost-reporting periods beginning during Federal fiscal year 1984, transition payment rates will be a blend of 25 percent of the applicable Federal rate and 75 percent of the applicable hospital-specific rate. However, as explained in section III.D. of the preamble to these interim rules, we have decided to pay the full outlier payment for outlier cases, rather than to pay only a percentage equal to the Federal portion percentage of the blended rate. As a result, both the Federal rates and the hospital-specific rates must also be adjusted so that when payments based on them are combined with the outlier payments, the resulting aggregate payments equal the payments from full Federal or hospital-specific rates with no outliers.

The determinations of the outlier payment criteria budget neutrality adjustments was done only with respect to hospitals that will be reimbursed under the prospective payment system, since outlier payments and standard payments under the prospective payment system will not be on behalf of exempt hospitals and hospitals in waiver States. Reimbursement to exempt hospitals and hospitals in waiver States is not changed by the provisions of the prospective payment system.

The outlier criteria were calibrated using experience in the 1981 MEDPAR file so that outlier payments would be 6 percent of standard payments. Since budget neutrality is determined based on total payments, the outlier payments should be compared to total payments (the sum of standard payments and outlier payments). Example: Suppose standard payments are $100 so that the desired outlier payments would be $6. Outlier payments as a percent of total payments would be $6 divided by ($100 + $6) = 5.7 percent.

The outlier adjustment ratio for Federal rates is calculated by dividing

the total estimated payments on the basis of Federal rates by the sum of the Federal rate payments and the outlier payments. The outlier adjustment ratio for hospital-specific rates is calculated by subtracting the outlier payments (as calculated from the DRG-adjusted Federal rates, as adjusted for outlier payments and budget neutrality) from the hospital-specific payments and dividing the result by the hospital-specific payments. The budget neutrality adjustments are applied to the outlier-adjusted Federal rates and the outlier-adjusted hospital-specific rates.

Example: Computation of outlier adjustment ratios of Federal rates and hospital-specific payments

Estimated Values

Federal rate payment per discharge (before outlier adjustment), $3,403.33
Federal rate outlier payment per discharge (before outlier adjustment)*, $207.44
Hospital-specific payment per discharge (before outlier adjustment), $3,348.96

Computation of Federal Rate Outlier Adjustment ($3,403.33 + $207.44) × Federal rate outlier adjustment = $3,403.33
Federal rate outlier adjustment = $3,403.33 ÷ $3,403.33 + $207.44
Federal rate outlier adjustment = .943
Outlier adjusted Federal rate payment per discharge = $3,403.33 × .943 = $3,209.34.

Computation of Adjusted Outlier Payment per Discharge

To compute the HSP outlier adjustment, we must first determine the outlier payment per discharge as adjusted to take into account outlier and budget neutrality adjustments to the Federal rates. The estimated outlier payment used above was derived from unadjusted Federal rates. Since the actual outlier payments are derived from Federal rates that have already been adjusted for outlier payments and to achieve budget neutrality, the outlier payments will also indirectly reflect those adjustments. To take this into account in computing estimated outlier payments, the outlier payment per discharge must be adjusted by the Federal rate outlier adjustment of .943 and the Federal rate budget neutrality adjustment factor of .969. Therefore, the adjusted outlier payment per discharge (as calculated from the adjusted Federal rate) = $207.44 × .943 × .969 = $189.56

Computation of HSP Outlier Adjustment

($3,348.96 × HSP outlier adjustment) + $189.56 = $3,348.96
HSP outlier adjustment = $3,348.96 − $189.56 ÷ $3,348.96
HSP outlier adjustment = .943
Outlier adjusted HSP standard payment per discharge = $3,348.96 × .943 = $3,158.07

G. *Calculation of Budget Neutrality Adjustment Factors*

As noted above, we must compute two budget neutrality adjustment factors—one for adjusting Federal rates and the other for adjusting the updating factors used to determine the hospital-specific rates.

For the Federal rate system, the following equation must be solved:

(Federal standard (outlier adjusted) payment per discharge + Outlier payment per discharge (computed from outlier adjusted Federal rates)) × Federal rate budget neutral factor (FRBN) + Federal rate system nonoperating cost per discharge = TEFRA operating reimbursement per discharge + TEFRA nonoperating cost per discharge.

Example: Computation of Federal Rate Budget Neutrality Adjustment Factor

Estimated Values

TEFRA operating reimbursement per discharge, $3,266.10
TEFRA nonoperating cost per discharge, $350.06
Federal rate standard payment (outlier adjusted) per discharge, $3,209.34
Federal rate outlier payment (based on above number) per discharge, $195.62
Federal nonoperating cost per discharge, $318.28

Solve:
($3,209.34 + $195.62) × FRBN + $318.28 = $3,266.10 + $350.06
$3,404.96 × FRBN + $318.28 = $3,616.16
FRBN = $3,616.16 − $318.28 ÷ $3,404.96
FRBN = .969

For the HSP system, the following must be solved:

(HSP payment per discharge × hospital-specific budget neutral factor (HSBN) + Outlier payment per discharge adjusted for Federal rate budget neutrality + HSP system nonoperating cost per discharge = TEFRA operating reimbursement per discharge + TEFRA nonoperating cost per discharge.

Example: Computation of Hospital-Specific Rate Budget Neutrality Adjustment Factor

Estimated Values

TEFRA operating reimbursement per discharge, $3,266.10
TEFRA nonoperating cost per discharge, $350.06
HSP payment per discharge (outlier adjusted), $3,158.07
HSP outlier payment per discharge (based on outlier adjusted Federal rates), $195.62
HSP nonoperating cost per discharge, $318.28
Federal rate budget neutral factor (FRBN), .969

Solve:
($3,158.07 × HSBN) + ($195.62 × .969) + $318.28 = $3,266.10 + $350.06
($3,158.07 × HSBN) + $507.84 = $3,616.16
HSBN = $3,616.16 − $507.84 ÷ $3,158.07
HSBN = .984

Note that the HSP budget neutral factor is not applied to the outlier payments. Outlier payments are paid in full based on applicable Federal rates, which already incorporate an adjustment for budget neutrality.

Note that payments per discharge were computed at 100 percent for purposes of the budget neutrality calculations. The calculated budget neutrality adjustment factors would be unchanged if computed from Federal rates at 25 percent compared with payments under prior law at 25 percent, and HSP rates at 75 percent compared with prior law payments at 75 percent.

H. SUMMARY—TABLE OF OUTLIER AND BUDGET NEUTRALITY ADJUSTMENT FACTORS—FEDERAL FISCAL YEAR 1984

Adjustment factors	Federal rates	Hospital-specific rates
Outlier	0.943	0.943
Budget neutrality	0.969	0.984

* This payment per discharge was calculated by applying the cost and length-of-stay outlier criteria to the MEDPAR experience and using all discharges, including discharges for which no outlier payments would be made.

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